Contract No. 200-90-0835

REPORT

Final Report

For

Task 28

HIV Prevention

Community Planning

Case Studies

Washington, DC

Los Angeles, CA

To Centers for Disease Control and Prevention

1600 Clifton Road

Atlanta, GA 30333

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APRIL 1995

HIV PREVENTION COMMUNITY PLANNING CASE STUDIES

WASHINGTON, DC
LOS ANGELES, CA

Final Report

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Task 28

APRIL 30, 1995

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Overview

This is a descriptive case study of the HIV Prevention Community Planning Process in Washington DC and in Los Angeles County CA. The study's purpose is to enhance understanding of a new process.

This report details the many issues that have emerged as HIV prevention community planning was implemented in 1994. It also highlights the many positive accomplishments of the two jurisdictions that participated in the case studies.

The study is retrospective in the sense that Battelle researchers conducted their study between November 1994 and January 1995, but mainly discussed with respondents events that had occurred during the summer and early autumn of 1994. However, issues pertaining to the initiation of community planning prior to this timeframe, and ongoing events since the October 3 deadline for submission of a Comprehensive Community Plan, are also included when germane to our description of community planning.

Background and Method

Beginning in FY 1994, the Centers for Disease Control and Prevention (CDC) implemented a new requirement for obtaining cooperative agreement funds for HIV prevention. At that time state, territorial, and local health department grantees were required to convene a prevention community planning body. This body was to participate in the development of the FY 1995 prevention plan. A Supplementary Guidance document provided specific criteria for setting up community planning groups as well as guidelines for completing a Comprehensive HIV Prevention Plan and funding application, due on October 3, 1994.

In order to contribute to an understanding of this process, Battelle researchers conducted a series of interviews with members of the HIV Prevention Community Planning Groups (CPGs),[1] key local health department staff, and several members of the community not on the CPGs. We also observed planning meetings and analyzed a number of documents, including the HIV prevention

[1] The two jurisdictions refer to their CPGs as prevention community planning committees (PCPCs). However, in keeping with the acronyms adopted by CDC, we will refer to the committees as CPGs, or community planning groups.

comprehensive community plans and the funding applications themselves. All interview data were entered into text analysis software, while documents and meetings were summarized. This enabled researchers to code data by theme. The results of this analysis form the body of the case study.

The data which form the body of this report were obtained from the CPGs and local health department grantees in Washington DC and Los Angeles CA. Battelle was asked to focus on these two cities, while another organization (the US Conference of Mayors) was profiling community planning in nine other jurisdictions.[1] The two study sites were chosen based on a variety of criteria including (1) geographic diversity, (2) racial and ethnic diversity, (3) HIV prevalence and incidence and AIDS cases, (4) previous experience with formal community planning processes, and (5) type of community planning process proposed. Research questions focused on the *process* of community planning, although we will discuss some of the information contained in the Comprehensive Prevention Plan submitted by each site in order to illustrate particular process points. The questions were open-ended and elicited many opinions as well as facts. Thus, the report is written largely from the perspective of participants, with Battelle's conclusions in the chapter summaries and the final chapter.

Initiation of the Community Planning Process

Nomination and selection. Community Planning was initiated in the District of Columbia through a Working Group established by the Agency for HIV/AIDS (AHA). The Working Group, which predates the CPG, implemented an open membership nomination process that relied on advertisements in the District's main newspapers targeted to the gay community and to the African-American community. Many people heard about the formation of the CPG through word-of-mouth. Most respondents were satisfied with the nomination and selection process, although some concern was voiced regarding lack of representation from smaller ethnic groups. Still, members represented multiple areas of expertise, and populations such as the deaf community were represented in the CPG.

Los Angeles County is large and diverse, with 36 percent of the AIDS cases in the State of California. AIDS Programs (AP) within the Los Angeles County Department of Health Services initiated the community planning process. The present CPG, known as the Prevention Planning Committee, was created in 1994, specifically to address *prevention* planning as mandated by CDC. A unique feature of the Los Angeles CPG is that it is a select committee within the Ryan White Planning Council.

In order to select a representative and inclusive group, the AP conducted a nomination process using five mailing lists targeted to 1,700 recipients. Unfortunately, some constituencies were not satisfied with the nomination form, so a second mailing was sent. This may have resulted in confusion, although respondents who had been involved with nominations and selection felt they were successful in bringing new, but highly qualified people to the table. They point out that the mailing lists contain names of people from very diverse settings such that AP was reaching out to persons often not found in HIV/AIDS planning.

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[1] Seven of these jurisdictions were states, one a city, and one a territory.

Implementation and structure. The Washington DC CPG convened in late June 1994 and the Los Angeles CPG convened in early July 1994. Both groups held orientation meetings.

The CPG co-chairs in both cities were selected according to criteria set down in their bylaws and CDC guidance. Los Angeles selected an additional community co-chair, bringing their total to two community co-chairs and one government co-chair. Both CPGs made use of ad hoc subcommittees to complete the work of planning. Subcommittee members serve on a volunteer basis, aside from their work in the full CPG. The subcommittee structure in DC was formalized with a "point person" for each subcommittee responsible for the flow of information among the subcommittees. There was some difficulty in fully implementing this procedure. Time pressures were cited as a major reason limiting the ability of subcommittee members and heads to communicate optimally.

Both groups actively sought to create representative and inclusive bodies and consider members to be representatives of multiple constituencies, rather than a single agency. Although the DC CPG formally consists of 42 member slots, only about 20 to 25 people have been active participants in the group. In Los Angeles, AP staff determined from the outset to have a body of 20 to 25 people. They posited that this size would enable the group to make critical decisions in a timely manner.

In order to supplement the membership of the LA CPG, the group uses the expertise of non-voting Advisors to address a number of issues, such as epidemiology, deaf and hard of hearing, the state community planning body, national policy issues, and the needs of particular populations. Washington DC does not use formal advisors but has two ex officio members on its CPG, who are members of the Ryan White Planning Council. In addition, several AHA staff members, including the Acting Administrator, attend meetings in an advisory capacity.

Practical assistance. Members in Washington DC may be reimbursed for parking or travel expenses, and deaf members received the assistance of interpreters. Repeated controversies arose over the best meeting times. As a compromise, a decision was made to alternate meetings between mornings and evenings. This is an important issue because the CPG and subcommittees met several times a month during the summer.

In LA, AP also provides interpreters for the deaf advisor, as well as parking and travel reimbursement.

Development of the Community Plan

According to CDC guidelines the Comprehensive Community Plans are to be based largely on an epidemiologic profile and a needs assessment. The two jurisdictions conducted these tasks in ways that reflect both CDC guidelines and their own configurations and constituencies.

Information for planning. In Washington DC, epidemiologic staff from AHA presented an epidemiologic profile to the CPG. Respondents expressed concern regarding gaps in epidemiologic information, although those with knowledge of the field were aware that there are many constraints on the ability of staff to collect such data. These data could be supplemented with a needs assessment, and it had been hoped that a very thorough assessment would be accomplished in the first year of community planning. However, most respondents agreed that the time remaining for community

planning from the date the members were selected and oriented—about three months—was not sufficient to accomplish this goal.

The subcommittee responsible for prioritization of populations and interventions in DC believed that the process they used, based on CDC guidelines, was valid and that their rankings were accurate. They arrived at consensus among themselves and presented the results to the CPG as a whole. However, some respondents from the CPG were critical of the results of the prioritization process and of the interventions chosen because they did not feel sufficient information had been gathered upon which to base prioritization and planning. These issues were discussed at meetings and the CPG reached consensus deciding to first submit the Plan and then fill in gaps after the October 3 deadline. For example, one suggestion is to conduct focus groups with members of smaller ethnic groups within the District that may be missed in surveys and epidemiologic surveillance.

In LA County, the epidemiologic profile was created by two members of the Department of Health Service's HIV Epidemiology Program and was reviewed by the CPG. It used multiple sources of information, summarized AIDS case data, and included seroprevalence and seroincidence data. Despite the utility of these data, dissatisfaction with the lack of behavioral information was expressed. Target populations were identified through the epidemiologic data and through the needs assessment done as part of the Strategic Plan already in place at AP.

A process is now being conducted in LA that includes (1) identifying all community groups and service providers involved with HIV and AIDS prevention; (2) conducting telephone interviews with service providers; (3) sending a mail survey to service providers; (4) conducting outreach interviews with members of the community; (5) conducting 13 public hearings across the County; and (6) conducting focus groups with community members. This process is meant to expand the needs assessment.

Barriers and Solutions

The CPGs experienced many pressures and found ways of dealing with them that may provide useful lessons to other jurisdictions. Other barriers were more difficult to surmount, but the experiences of respondents may also be helpful to others engaging in community planning.

Timeline. The October 3 deadline for submission of the Plan and funding Application was a driving force throughout the entire process for both jurisdictions, with slightly less stress expressed by LA respondents. Combining the data for both sites shows that the impact of the timeframe can be summarized as follows:

- It constrained the groups' ability to complete tasks necessary to develop a complete and innovative plan.
- It led to reliance on older data than many respondents would have liked to use for planning.
- It constrained full participation by all members.

- It prevented members from fully talking through differences of opinion.
- It constrained greater grassroots community involvement.

On a positive note, several respondents used terms such as "bonding" to indicate that dealing with the pressure may have created a greater sense of cohesion among core members.

Purpose. Despite an extremely high level of commitment to the Community Planning process participants did not feel they had a clear sense of the purpose of the CPG. However, when probed, respondents from both jurisdictions cited several purposes similar to those that had been stated by CDC or the local grantee. In addition, a number of members in both locations added a monitoring or oversight component. The purposes that we elicited from the data are:

- Produce a product, the Comprehensive Community Plan.
- Enhance community involvement in the planning process.
- Act as an advisory body to the local health department.
- Determine priorities for funding prevention services.
- Provide monitoring and oversight of HIV prevention activities.

The strongest disagreement among respondents revolved around the appropriateness of involvement in monitoring, oversight, and funding decisions.

Conflict. AHA in the District of Columbia referred to the use of CDC guidelines to establish conflict resolution mechanisms. However, most members were unaware of such formal guidelines, simply stating that they "talked things through as adults" when conflict arose. Robert's Rules of Order were used to formalize discussion and reach consensus.

Similarly, in Los Angeles, conflicts are resolved through mutual trust and respect. Unlike Washington, though, members reported that they question the need to adhere to parliamentary procedure, finding it too formal.

Membership and attendance. Members and advisors in both jurisdictions were chosen for expertise in various areas of HIV prevention and education, as well as to represent varying constituencies. However, they were *not* chosen to represent agencies. The conscious decision to de-emphasize organizational affiliation was seen as a way of focusing on the totality of what each member can bring to the table, and respondents reacted positively to being called upon to use the full array of their backgrounds and capabilities.

However, because many of them represented multiple constituencies, DC members reported that it had become difficult to choose alternates for members unable to attend. This issue is in the process of being revisited. It is important since irregular attendance was one of the major problems for the DC CPG. Attendance and membership rules are also being reviewed at this time.

Regular attendance at CPG meetings is a requirement for both jurisdictions. For example, missing three meetings in a row is grounds for dismissal in Los Angeles. During the study period no one was dismissed for missing meetings; however, this did occur in February 1995 in LA.

Training. DC respondents reacted favorably to a two-day orientation offered by AHA when the group was formed. However, more time needed to be spent on team building, and a few members found the amount of written information overwhelming. In fact, a need for more frequent training in process issues was noted, as well as a desire for more practical information. For example, controversy surfaced over the meaning of primary and secondary prevention and the relevance of this concept to HIV prevention and education.

In LA, aside from an orientation, five workshops were given at CPG meetings. Two were on epidemiology, one was on the needs of the deaf, another on the incarcerated, and the last session was about issues facing transgender individuals.[1]

Lessons learned. The CPGs set very high standards for themselves. The level of expertise was high, as was the commitment of the core group of members. Washingtonians offer advice to other jurisdictions based on what has worked well for them. The advice includes (1) keeping an open nomination process, (2) using subcommittees and small group work, (3) utilizing whatever training and technical assistance is available, (4) de-emphasizing employee affiliations, and (5) serving refreshments at meetings. In addition, one member cautioned that when embarking on the planning process it is not possible "to accommodate everyone," while others pointed out the need to remember that community planning is a new process that takes time.

Los Angeles CPG members agreed that subcommittee work is beneficial. They added two other insights, which are (1) to keep the group a manageable size, and (2) to use advisors to supplement the expertise on the CPG. Respondents also advised that CPGs engage in a retreat or team-building activity.

Community Planning and the Larger Community

Community input. Members agreed that a community cannot be defined by a broad geographic entity such as the District of Columbia or Los Angeles County. They believe that the community planning process enhances a sense of community through mutual respect, rapport, and greater knowledge of different populations. The enhanced sense of community comes from the experience of working across populations on a common undertaking.

The DC CPG bylaws established a mechanism for reaching out to the community at the grassroots level through its proposal to implement additional groups consisting of members from four key constituencies (general public, community associations, religious groups, consortia). However, this proposal was put on hold, largely because of time pressures to complete the Plan. The newly hired CPG Coordinator is now taking steps to implement this strategy for increased community input.

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[1] In 1995, subsequent to the time of this study, Washington DC also implemented educational presentations at CPG meetings.

Other outreach efforts included two Town Meetings, one at the inception of community planning in the Spring of 1994, and another in late September 1994 to unveil the Plan. All CPG meetings are open to the public.

In Los Angeles, efforts to involve the larger community also increased once the Plan was completed on October 3. These activities are meant to update and expand that submission and include public hearings, outreach interviews, and focus groups.

Relationship with other planning bodies. The DC CPG is an independent body. Two members of the Ryan White Planning Council sit on the CPG as ex officio members. Communication between the two entities appears to be good. The LA CPG is a select committee of the Ryan White Council.

Conclusions

Prevention community planning has been fueled by the dedication of participants in both jurisdictions. The CPGs were able to carry out their goal of submitting a Plan by the October 1994 deadline through the commitment of their members, the local health departments, and CDC.

The purpose of the case studies of the HIV prevention community planning process in these two urban jurisdictions has been to allow participants in these cities, participants in other CPGs, and CDC to learn about the issues that emerged during the first year of planning and the ways that the two groups have dealt with them. As a descriptive case study, its goal is to aid in understanding.

Issues where the greatest similarities and differences emerged have been summarized. In cases where the data lend themselves to suggestions for assistance, we have included those as well. We realize that, unfortunately, local structural and fiscal problems exist that affect optimal community planning and are outside the purview of CDC. We also realize that we are writing about the experiences of two urban grantees out of a total of 65 grantees; whereas only seven[1] of these 65 are cities. These experiences and our interpretations may not be generalizable. Even so, they may offer possibilities for assisting new jurisdictions who may find a number of the same issues emerging as they embark on HIV prevention community planning.

Inclusiveness and representation. Both groups cast a wide net in order to establish an inclusive and representative planning body. The nomination and selection processes were generally rated well by respondents. Yet, tension between diversity and tokenism emerged due to the need to choose members based on constituencies. Even with broad-based efforts toward inclusion, both jurisdictions wish to bring in more grassroots representation. On a practical level, one respondent requested that CDC assist jurisdictions in expanding their advertising for members.

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[1] Six cities are funded through the CDC HIV Community Planning Cooperative Agreement. The cities are Los Angeles, San Francisco, Houston, Chicago, New York, and Philadelphia. Washington DC was funded as one of the nine territories, although it is a wholly urban entity.

Purpose. In both cases, there was uncertainty about the purpose of the CPG itself even though the purpose had been expressed at orientation meetings and in written material. In particular, community members were unsure of the appropriate degree of advocacy and monitoring for the planning group to undertake. It may be helpful to recognize that the purpose of the groups may evolve somewhat in response to the realities of the jurisdictions and to provide guidance as this occurs.

Structure. Both jurisdictions utilized subcommittees to accomplish specific tasks. Washington DC was handicapped by District policies that prevented them from hiring a coordinator who could have pulled together the work of the four ad hoc subcommittees within the larger CPG. (The coordinator was hired in January 1995.) The Los Angeles CPG had two full-time coordinators within AP.

The most substantial difference between the two groups was the fact that the Los Angeles County CPG has a unique relationship with the Ryan White Planning Council as a select committee. An apparent difference was the moderate size of the Los Angeles group relative to the size of the County. Interestingly, while the Washington DC CPG has almost twice as many member slots as does the Los Angeles group, the number of active members in each group was about the same. This may be evidence that a membership of about 25 is well suited to community planning in an urban context.

Community input. Both jurisdictions are increasing their outreach to the community as a whole. Respondents believed that, overall, community planning is enhancing the sense of community and wished to guard against using the process to enhance self-interest or the interests of a small group. They agreed that an entire jurisdiction is too large to be a single community, and some expressed concern about the needs of subpopulations within larger recognized communities, such as the various ethnic groups that compose the Hispanic population. As the community concept is broadened to include more constituencies, assistance in achieving parity may be greatly appreciated by jurisdictions.

Training. Members were clear that training is necessary in both technical and process issues. There is a consensus that everyone should attend orientation and that a retreat format is especially useful. Data show that the amount of written information was overwhelming to some respondents in both constituencies. One suggestion made was for small packets of material in bulleted form.

An interesting challenge for technical assistance and guidance is to balance community involvement with the development of a scientifically robust prevention plan. A tension may exist between the energy and drive that fuel the process of HIV prevention community planning and the need for a scientific foundation for decision making. Conducting short workshops at meetings has been one way of addressing this issue.

Timeline. Time constraints affected everything the CPGs did and restricted what they could do. Time especially affected their ability to conduct a full needs assessment to supplement available epidemiologic information. While respondents spoke about the cohesion that developed from working together under so much pressure, others felt it was impossible to air difficult issues to everyone's satisfaction in the time allotted. We wonder if some respondents had unreasonable expectations of themselves. This may mean that CPGs need assistance in prioritizing the elements of the Plan that require the greatest focus in each funding cycle.

Summary. Summarizing across sites, the major difficulties faced were in the areas of (1) meeting the deadline, (2) clarifying the purpose of the CPG, and (3) including people from the community as a whole. The major strengths of the groups were (1) their ability to complete the Plan on time, (2) their ability to achieve consensus, (3) the types of expertise among group members, and (4) a strong commitment on the part of the health departments to act as partners in the community planning process.

Chapter 1.0

Overview

1.0 Overview

This report is a descriptive case study of the *HIV prevention community planning (CP) process* in two jurisdictions, Washington DC and Los Angeles CA. The case studies focus primarily on the period of time from June through October 1994; however, events before and after the study period are included as necessary. Descriptive case studies report on phenomena within their own contexts;[1] in the case of the HIV Prevention Community Planning process, the phenomenon is ongoing and will continue to develop even beyond the writing of this report.

The case studies are a part of a multi-pronged evaluative endeavor by the Centers for Disease Control and Prevention (CDC) that includes data collection by grantees, tracking of community planning resource allocations, and qualitative studies conducted by providers of technical assistance. In addition, a series of case studies was undertaken by the US Conference of Mayors in nine jurisdictions. As with all of the case studies, the purpose of this document is to provide information that will assist the reader in better understanding the process of HIV community planning. The following section provides background information on community planning and elucidates the methods Battelle used to achieve its purpose.

1.1 Background and Methods

Beginning in 1994, the Centers for Disease Control and Prevention implemented a new requirement for obtaining cooperative agreement funds for HIV prevention. At that time, 65 state, territorial, and selected local health department grantees were required to convene a prevention community planning body that was to participate in the development of the FY 1995 *prevention plan* and its *application*. A *supplementary guidance document* prepared by CDC provided specific criteria for setting up *community planning groups*, as well as guidelines for completing a comprehensive HIV prevention plan, due on October 3, 1994.

The Plan was to be based in part on an *epidemiologic profile* of the community and a *needs assessment*, along with an assessment and prioritization of interventions. The overall purpose of the

[1] Yin, Robert K. *Case Study Research: Design and Methods*. Newbury Park: Sage, p. 23.

epidemiologic profile for community planning was the identification of priority target populations. Critical to the development of the Plan was the establishment of the community planning group (CPG), a representative body of individuals who could add the community perspective to the planning process. As stated by CDC,

> "The expertise of community representatives [is] essential in filling the gaps in the data and assessing the data in the context of local prevention needs, based on their first-hand familiarity with groups at risk for, or infected with, HIV."[1]

The two jurisdictions profiled in this report—Washington DC and Los Angeles CA—were chosen based on a variety of criteria. They are (1) geographic diversity, (2) racial and ethnic diversity, (3) HIV prevalence and incidence and AIDS cases, (4) previous experience with formal community planning processes, (5) and type of community planning process proposed.[2]

In order to describe the process that began as local health department grantees initiated the CPGs through submission of their HIV Prevention Plans in October 1994, Battelle has used a descriptive case study methodology. This methodology consists of (1) review of relevant documents for each city, (2) one-on-one interviews with a sample of CPG members and key local health department staff, (3) group interviews with additional CPG members, (4) observation of CPG meetings, and (5) telephone interviews with a sample of non-CPG members. We provide further information on methods employed for the two study sites in Chapters 2 and 3 (for Washington DC and Los Angeles, respectively). The questionnaires themselves were developed according to a set of core items of interest to CDC and are attached as Appendix A.

All interview data were analyzed using *Ethnograph*® software for ethnographic text analysis. Documents were summarized by theme. In the body of the report, the respondents speak for themselves, but we do offer interpretations of the data when varying views are present. At the end of the document, we draw conclusions based on the data and our interpretations.

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[1] AED/CDC *Handbook for HIV Prevention Community Planning*, April 1994, p. 4-1.

[2] The U.S. Conference of Mayors conducted a series of nine case studies mainly focusing on states (Arizona, Florida, Indiana, Kansas, Maine, New York, Oregon) as well as the city of Chicago and territory of Puerto Rico.

1.2 Goals of Report

As a descriptive case study, the main purpose of this report is to provide information and interpretations through a method that focuses on the specific goals of community planning as seen through the participants in that process. The report also details the many issues that emerged from the process of community planning, such as different views of the purpose of community planning groups, needs for training and technical assistance, and manners of coping with the timeline for submission of the Plan and Application.

It is our hope that this report will allow the members of each of the two jurisdictions that form the subject of this report to appreciate what they have accomplished. At the same time, the participating jurisdictions, CDC, and other jurisdictions will have an opportunity to learn from the efforts of the participants in these case studies.

1.3 Organization of Report

This report is organized into four chapters preceded by an Executive Summary. The Overview (Chapter 1) presents background information about the CDC mandate for HIV Prevention Community Planning and about the structure of this report itself.

Chapters 2 and 3 present the case studies for Washington DC and for Los Angeles County, California. The case studies describe how the Prevention Community Planning Groups were established, including detailed information on factors that facilitated and hindered the convening of the groups. The focus is much less on the outcome of the groups' efforts, the FY 1995 Prevention Plans, than on the *process* used by the Committees to produce the Plans. Continuing efforts since October 1994, as well as broader community issues, will be addressed where relevant.

The final chapter presents our conclusions about the community planning process. We pay special attention to those aspects of the process that were particularly beneficial or problematic. It is hoped that the experiences related here can inform others who enter into this process in the future.

Chapter 2.0

Washington, DC

2.0 Washington, DC

We begin our discussion of HIV Prevention Community Planning in Washington DC with a description of the methods utilized for conducting this case study. We then discuss each element of the planning process, the Plan itself, barriers and solutions to planning, and community responses. The case study of Washington DC ends by highlighting strengths of the process in this jurisdiction.

The data in this study are drawn from two main sources—documents and interviews. The documents used and the categories of respondents interviewed are listed in Table 1. A meeting held on January 12, 1995, was also observed—even though it occurred after the study period—because it illuminated the general group process.

In most cases, we did not ask CPG members direct questions about the constituency they represent because most members felt they represented multiple constituencies. Except in rare instances, we have omitted information on the affiliation of interviewees to protect confidentiality. Throughout this chapter, the term *respondents* encompasses all health department and CPG interviewees, including co-chairs and consultants; the term *members* refers to CPG members but not co-chairs.

We chose a diverse group of respondents for interviewing. Using the membership list for the CPG subcommittees, we chose one representative from three of the four groups and two from the largest group. We supplemented this list with information contained in brief biographical sketches submitted to CDC as Appendix C of the Comprehensive Plan. In this way, we were able to choose persons representing different affected groups and participants with varying professional, advocacy, and volunteer backgrounds.

Community respondents who were not members of the CPG were identified directly through the attendance record of a town meeting held in late September or through the recommendation of another respondent in the study. This method of identifying general community respondents resulted in a cross-section of persons from academia, religious organizations, and activist groups. All of these respondents were interviewed over the telephone. Since their knowledge of the community planning process and the Plan varied considerably, we adjusted our interview questions to each situation. The comments of non-CPG community members are summarized in Section 2.4.3 of this chapter.

Table 1
Data Sources—Washington, DC

Documents

- "Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of HIV Prevention Projects" (CDC - January, 1994)
- "District of Columbia HIV Prevention Community Planning Project Plan and Application" (February 24, 1994)
- *Handbook for HIV Prevention Community Planning* (AED/CDC - April 1994)
- "*Executive Summary* of the Evaluation of CDC Funded HIV Counseling and Testing and Education and Prevention Programs in the District of Columbia" (October 1994)
- "HIV/AIDS Prevention Assistance Initiatives in the District of Columbia" (October 3, 1994)
- "Comprehensive HIV Prevention Plan for the District of Columbia" (October 3, 1994)
- Minutes of the District of Columbia HIV Prevention Community Planning Committee (June 28, 1994 through December 8, 1994)

Respondents

- Prevention Community Planning Group (CPG) members (14 interviewees) and Co-Chairs (2 interviewees)
- Government staff or consultants directly involved with the community planning (CP) process, but who are not CPG members (3 interviewees)
- Community "key informants" (7 interviewees).

It was not possible to schedule a group interview for CPG members at a mutually convenient time, but members who had expressed interest in the group interview were interviewed by telephone. All face-to-face interviews and most telephone interviews were conducted by a primary and secondary interviewer, with both taking notes and collating them after the interview. The notes were then entered into *Ethnograph*® software, which enabled the coding of each interview by theme. These themes form the basis of this report. The ethnographic analysis also allows for presentation of the range of responses to particular themes as well as counts of persons in agreement with specific questions.

2.1 Developing a Community Plan

2.1.1 Initiation of the Community Planning (CP) Process

As a first step in complying with CDC's mandate for community planning, the District of Columbia's Agency for HIV/AIDS (AHA) of the District's Commission for Public Health (CPH), convened a meeting of more than 25 community leaders on October 15, 1993. This meeting generated an HIV Prevention Community Planning Working Group.

The 25 participants in the Working Group represented 24 agencies and organizations. Most were employed by community-based organizations (CBOs) providing a variety of services such as education, counselling, and health care. Participants included one youth, people from sectors of the District government both within and outside of the public health commission,[1] and representatives from religious and higher education organizations. Staff from AHA and CPH advised the group.

A stakeholder analysis; the creation of bylaws; the development of administrative rules; member nomination, screening, and development of membership criteria; and other procedures were accomplished by the Community Planning Working Group. One of the work group's initial steps was to form subcommittees to deal with each of three areas: Community Process, Community Planning, and Bylaws. The bylaws were adapted from those of the Ryan White Planning Council to meet the anticipated needs of the new Community Planning Group. As we will see, some of the methods

[1] Sectors include counselling and testing, STD, surveillance and epidemiology, mental health services, youth services, substance abuse prevention and treatment, public schools, and corrections.

for obtaining community input were put on hold due to the urgency of developing the HIV Prevention Plan; other issues, such as delegation of alternates, are now being revisited. The Working Group developed a structure for reaching out to the community for nominations and created a blueprint for community planning; this structure includes a series of stakeholder interviews, the use of town meetings, and the solicitation of nominations from various community groups.

2.1.2 The Member Nomination Process

An open process for recruiting and selecting members for the CPG was crucial in order to meet CDC's mandate for inclusiveness and representation.[1] The Working Group sought to ensure that the mandate was met by convening a town forum; they also printed the Application in the District's largest newspaper targeted to the gay and lesbian community, as well as that targeted to the District's African-American community. Several interviewees told us they had applied through this venue; others applied at the urging of a friend or colleague.

AHA and the Working Group developed criteria for screening the nominations. The screening panel consisted of five people not in the Working Group; the screeners were disqualified from rating anyone they knew. Applications were also blinded. AHA and a member of the Working Group pooled the rankings and looked for gaps in representation.

It was a goal of the District to "make the playing field level" in order to increase community participation. Criteria for selection included professional expertise or experience in HIV/AIDS prevention and education or other health promotion, level of community involvement, and level of interest. An optional question requested information on affiliation with a variety of potential target populations (e.g., gay or bisexual, ethnic groups, HIV infected persons or people living with AIDS, disabled). An active member of the Working Group reported that members felt it was their "responsibility" to have a cross-section of the community.

Responses from interviews with CPG members showed a high level of satisfaction with the results of the nomination process. Most agreed that the process was open because of the advertising and because "everyone had an opportunity to be nominated. People could nominate themselves."

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[1] Inclusiveness is the "assurance that all affected communities are represented and involved in a meaningful manner in the community planning process." *Representation* is the "assurance that those who are representing a specific community truly reflect that community's values, norms, and behaviors." Source: AED/CDC *Handbook for HIV Prevention Community Planning*, April 1994, p. 1-1.

One person who considers herself a strong advocate said that the process must have been open, given the fact that she was known to be very outspoken and was still chosen.

The majority opinion was that the nomination process promoted the goals of inclusiveness and representativeness. One person said, "They got a good cross-section of the community; a wide variety of people." Another person reasoned that if the process had been closed, the CPG would consist of "just friends," which it does not.

However, two responses showed concern that the CPG is not as diverse as it could be, with too few non-African-American minority members. While most respondents liked the advertisement (one called it "excellent"), a few called for broader advertising. For example, a Latina mother would probably not have seen the ads in the gay or African-American newspapers. One person found the nomination form somewhat confusing but appreciated the types of information being requested.

In sum, the nomination process met the goals of most government and community members. The few who expressed some disagreement were concerned about lack of representation from smaller cultural and linguistic groups.

2.1.3 Implementation of the Community Planning Group

The nomination and selection process took about two months to complete. Participants were notified of their acceptance on the CPG; they attended an initial meeting and a two-day orientation in June. As directed by CDC, the CPG chose two co-chairs. The newly hired Chief of HIV Prevention Services was appointed Health Department Co-Chair. The Community Co-Chair was elected at the first meeting, based on biographical information each of the three candidates shared with the other members. The co-chairs apparently work together closely, consulting on issues as they arise. The Community Co-Chair considers herself to be an advocate both for the community members on the CPG and for the community as a whole.

CPG Structure

There are now 42 member slots in the CPG. Of these, two are reserved for youth, who have not yet been chosen. Two slots were reserved for youths as it was felt that a lone young person

might feel intimidated. Meeting minutes show some discussion as to the best ages to consider and the special logistics of involving youth, such as transportation and school attendance.

Another challenge has been to include persons from the more disenfranchised groups, such as injection-drug users (IDUs). At this time, the approach is to include members, such as service providers and activists, who can represent these constituencies.

Despite the large size of the official body (42), approximately 20 to 25 of the members are active participants on the CPG, as reported in interviews and apparent in the list of attendees attached to the minutes for each of the CPG meetings. Issues pertaining to membership and attendance will be discussed further in Section 2.3 and in the summary of this chapter. The configuration of the Committee as of June 1994 is shown in Table 2 (one person may represent more than one constituency).

At this time, there are two ex officio members, both of whom are affiliated with the Ryan White Planning Council. The ex officio members do not vote and did not attend orientation; however, they attend the CPG meetings, and one was an active subcommittee member. One voting member accepted a seat on the Ryan White Council subsequent to appointment to the CPG.

Some debate arose over whether the government members should be voting or ex officio members; the six government members are full members. In addition, a number of government staff, including the Director of AHA, attend the meetings in an advisory capacity. Meetings are open to anyone who wishes to attend, although they are not advertised (probably for logistical and financial reasons). Respondents would welcome more community participation, a subject discussed further in Section 2.4.

Terms

One-half of the members hold two-year terms; the remainder hold one-year terms. CPG members drew straws at the first meeting to determine who would serve the two-year terms. One-year term holders may reapply, and any member may serve a maximum of two full terms. Based on the drawing of straws, the Government Co-Chair serves a one-year term and the Community Co-Chair a two-year term.

Table 2. CPG Composition[a]

Membership Category	Number of Representatives
Behavioral Science Representative	4
Correctional Facility Representative	1
State/Local Educational Agency Representative	1
Epidemiologist	2
Evaluation Researcher	3
Gay/Bisexual Men	14
Health Planning Representative	5
HIV/AIDS CBO Representative	14
Injection Drug User	0
Lesbian(s)	2
Local Health Department Representative	6
Mental Health Representative	3
Person(s) Under 21 Years	2[b]
Person(s) Living with HIV/AIDS	8
African American	18
Deaf	2
Political Office Holder	0
Latino/Hispanic	2
Religious Organization Representative	4
Asian/Pacific Islander	2
Substance Abuse Representative	3
National Organization Representative	2
University/College	2
Care Giver For HIV Infected	1
Total	42[c]

[a] DC HPCPC & AHA, *Comprehensive HIV Prevention Plan for the District of Columbia*, October 3, 1994. Appendix C.

[b] Two (2) member slots have been reserved for adolescent/young adult representatives. To date, no youth representative has been appointed to the HPCPC.

[c] One member may represent more than one constituency.

Subcommittees

The bylaws called for creation of an executive committee, which has not yet been established. The Executive Committee is to consist of between five and seven members. A suggestion was made at the second CPG meeting that two of those members be the co-chair candidates who had not been elected. Discussion ensued as to the need of the Executive Committee to be representative of the CPG as a whole. The members tabled discussion of the Executive Committee for 1994. Respondents pointed out that the Group as a whole needed to develop trust before decisions could be left to a smaller body of members.

At the third meeting, the co-chairs proposed the formation of four *ad hoc subcommittees*.

- **Needs Assessment (8 members).** Responsible for data inventory, data analysis, and oversight.

- **Focus Group and Informer Interviews (5 members).** Responsible for reviewing the District's Five-Year Plan for HIV/AIDS with regard to target populations in order to determine which populations would be targeted for focus groups. The subcommittee then convened focus groups and informant interviews as well as oversaw professional data compilation in order to make recommendations to the CPG as a whole.

- **Program Initiatives and Strategies (14 members).** Responsible for presenting to the CPG, in priority order, the top ten prevention strategies to be considered by the District. Recommendations were based on a list of prevention programs currently available in the District and included appropriate linkages among current programs.

- **Plan Monitoring Team (5 members).** Responsible for general "oversight" of the Plan as a whole and for assisting each subcommittee with technical knowledge based on a review of the Supplemental Guidance document from CDC. Also worked directly with AHA and the technical writer to ensure timely completion of the Plan and Application. Responsible for writing the letter of concurrence and for reviewing each component of the Plan for gaps to be addressed during the period between early October and early December.

CPG members chose to join a subcommittee based on interest and expertise. In four cases, a member chose to sit on more than one subcommittee. Later, each subcommittee sent at least one of its members to the Plan Monitoring Team. By far, the most active subcommittee was Program Initiatives and Strategies. Subcommittees made reports to the full committee and were responsible for sharing products they developed through a point person. However, this system encountered difficulty when the pressure of meeting the deadline did not allow one subcommittee to wait for another to

complete its tasks. This will be seen more clearly when we discuss some of the needs assessment activities the Program Initiatives Subcommittee undertook in order to support its prioritization activities.

Outside Consultants

The general work of coordinating the CPG has proven to be rather extensive. AHA contracted with an external meeting facilitator, who has been responsible for logistical and administrative support for the CPG. Funds were also committed to hiring a CPG coordinator; however, District personnel policies and procedures held up the appointment of this person until after the Plan was submitted. This caused an additional burden on both AHA staff and the contractor.

Technical consultants, both from inside CPH and identified by CPH for a limited period of time, were utilized to support development of the Plan. A doctoral student was largely responsible for working with the Needs Assessment Subcommittee. A technical writer was identified by AHA through contacts at the Ryan White Planning Council. The CPG clearly wanted to provide input into the hiring of this person who, along with designated AHA staff, would bear major responsibility for presenting the Plan in written form to CDC. AHA was authorized to complete the hiring process but allowed CPG members to attend the interviews and provide input. Other sources of technical expertise from within the government include the epidemiologist and the evaluator who did a brief process evaluation of community planning that was incorporated into the Plan.

Practical Assistance

AHA attempted to assist members, through its contractor, to the degree that it was logistically possible to do so. Member respondents identified six areas of practical need. In order of concern, as evidenced by the number of times mentioned, they are:

- Arranging convenient meeting times (6 responses)
- Child care and family issues (4 responses)
- The accessibility of meeting locations (4 responses)
- Interpreter services (3 responses)

- Reimbursement for parking or transportation (2 responses)
- Keeping members unable to attend meetings up-to-date (2 responses)

Some members thought that the health department staff preferred daytime meetings since that is when they work anyhow, but minutes show that AHA originally proposed an evening hour. After much discussion, it was decided to alternate meeting times such that one meeting would be held at 9 a.m. and the next at 6 p.m. This issue has been periodically revisited, especially as the CPG has been called upon to accelerate meetings or have emergency sessions.

AHA is unable to provide child care. A health department respondent told us that some type of arrangements (i.e., transportation) will have to be made when youth representatives are identified. At this time, the contractor attempts to find locations accessible by subway or bus. Parking and transportation reimbursement has been provided to members, but not everyone was aware of this fact.

Arranging for interpreters is one example of the grantee providing for the needs of members but having to cope with a situation beyond its control. With two deaf members on the Washington DC CPG, an interpreter has been critical to their participation; however, minutes show several meetings for which the interpreter arrived late or was completely unavailable. Recently, the problem has been exacerbated because the CBO providing this service has been unable to recover funds it is owed from the District and cannot pay its interpreters.

Two members were concerned that they did not receive information about meetings they missed, and one fell behind after she moved because the contractor did not have her new address. One person felt that a co-chair should be responsible for calling a member unable to attend.

The other major type of assistance offered to members was an *orientation*. Members appreciated the day and a half-long "retreat," especially the opportunity to meet each other. Reactions to the retreat illustrate a basic challenge to the ideal of parity.[1] While some members felt that the orientation consisted of "AIDS 101" and that more time should have been spent on team building and conflict resolution, others were highly appreciative of the basic information given on the epidemic and on the District's health department. Two people were concerned about the sheer volume of information new members were given and suggested that in the future summary documents

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[1] *Parity* is defined as "the condition whereby all members of the HIV prevention community planning group have equal opportunity for input and participation as well as equal voice in voting and other decision-making activities." Source: AED/CDC *Handbook for HIV Prevention Community Planning*, April 1994, p. 1-1.

with bullets highlighting important areas be prepared. Other training needs that emerged over time will be presented in Section 2.3.6.

2.2 Using Community Planning to Meet Community Needs

This section will discuss each of the steps the Washington DC HIV CPG undertook in order to produce its Comprehensive Plan. These steps include (1) utilization of an up-to-date epidemiologic profile to determine trends among different target populations, (2) development of a needs assessment, (3) identifying target populations, (4) prioritizing needs, and (5) development of the prevention plan itself. This section will discuss the ways in which the District of Columbia implemented these steps, as well as reactions to the Plan by CPG members and others.

2.2.1 Use of Epidemiologic Information in Community Planning

Development of an epidemiologic profile is considered crucial to "accurately targeting HIV prevention activities."[1] The Washington DC HIV/AIDS Epidemiologic Profile utilized two major sources of data: (1) AIDS surveillance data and (2) HIV serosurveillance data. Data from surrogate indicators, including sexually transmitted diseases (STDs) and number of live births per year, were used to aid in the identification of target populations. Seroprevalence data from a sentinel clinic for adolescents and from the DC Jail and the Juvenile Detention Center are useful for understanding trends but cannot be generalized to the population as a whole. Table 3 summarizes highlights of this profile most relevant to the issues raised by respondents in the interviews.

Responses to the Epidemiologic Profile

The epidemiologic profile was presented to the CPG by the head of surveillance for AHA. The three major problems raised by respondents were (1) insufficient time to digest the information before it had to be incorporated into the Plan, (2) reporting biases in the data, and (3) the difficulty of estimating HIV seroprevalence data accurately. While an effort was made to present the information in layperson's terms, it was not possible to deal with the subtleties of reporting data to everyone's

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[1] AED/CDC *Handbook for HIV Prevention Community Planning*, April 1994, p. 4-1.

Table 3
Highlights from the Epidemiologic Profile[a]

- The number of reported cumulative AIDS cases as of June 30, 1994 was 6,475, of whom 3,600 were known to be deceased (p. 36).
- Estimation procedures yielded an approximate range of from 11,500 to 17,000 District residents who are HIV infected, including persons presently living with AIDS. (Appendix E, p. 17)
- African-American men who have sex with men (MSM) are the largest single stratified category followed by white MSM (p. 36).
- IDU-related AIDS cases are increasing faster than non IDU-related AIDS cases (p. 38).
- Cases attributed to heterosexual contact increased by 750 percent from 1988 to 1993, showing the largest relative increase in that period. (Appendix E, p. 21)
- The relative increase of new AIDS cases for women is greater than for men, and women who were presumed to be infected through heterosexual contact tend to be younger than those infected through injection drug use (pp. 39-40).
- While the number of new AIDS cases among white MSM decreased in 1993, the five-year trend has been erratic (p. 24). In addition, there has been an increase in seroprevalence rates in the past two years in this group. (Appendix E, p. 27)
- The cumulative number of reported AIDS cases in the Hispanic community was 166, but CPH surveillance staff report difficulties in obtaining data for this group as well as for smaller ethnic populations in the District. This may be due to differential access to health care, or reporting biases. (Appendix E, pp. 24, 25, 27).

[a] DC HPCPC & AHA, *Comprehensive HIV Prevention Plan for the District of Columbia*. October 3, 1994. (Data are for 1993 unless otherwise specified.)

satisfaction. This may have been one reason for a number of conflicts that arose within the group.

Most interviewees doubted that all of the reported numbers were accurate and suspected reporting biases. Two respondents felt that numbers were simultaneously overreported by some organizations and underreported by others. Specific populations believed to be underreported include deaf persons, Hispanics, children, the chronically mentally ill (CMI), and the homeless. It was pointed out that the lag time between infection and diagnosis with AIDS among gay white men seems to be increasing, so that a reported decrease in AIDS cases may misrepresent the trend of the epidemic in that group. One member voiced a bind some advocates find themselves in due to present data sources and reporting mechanisms:

> "There is too much emphasis on AIDS diagnoses, but it's the best data we have. There is no question that there is a major crisis in African-Americans, women, and IDUs [intravenous drug users], but there is a piece missing."

Since there is no mandated HIV reporting in the District, it is necessary to look at trends reflected in other data sources. The epidemiologist "recognized that some numbers are not being captured" and shared this concern with the group. For example, within the Hispanic population, people who do not have green cards may not be going to clinics. This will affect both numbers of infections identified and the temporal trend for the population, meaning that members of this subpopulation may not be diagnosed until later in the disease process.

Respondents offered several suggestions in response to a direct question on how to improve the epidemiologic profile. Some of these suggestions extend beyond the scope of epidemiology per se, illustrating the urgency to some persons of incorporating additional information. Due to the small numbers of respondents who volunteered a suggestion, these are individual ideas:

- Quality assurance and follow-up to ensure better reporting.
- More attention to culture and beliefs that may affect the willingness of groups to report HIV and AIDS-related data.
- More "true" surveys that can reach populations on the grassroots level.
- Refinement of transmission categories, such as men who have sex with men (MSMs), IDUs, and heterosexuals.
- Use of more current data.

- "Find" people rather than waiting for them to come in for testing.
- Mandatory universal *anonymous* testing.

Members appreciated that the data were broken out by ward.

2.2.2 Needs Assessment

The DC HIV CPG and AHA recognized that a needs assessment is an integral part of the process for the HIV Prevention Plan and were committed to conducting as thorough an assessment as possible. In early July 1994, it was decided that the needs assessment would comprise the following six components:

- Developing an epidemiologic HIV/AIDS profile of the District of Columbia;
- Analyzing population-based survey data, including data from the National Health Interview Survey (AIDS Supplement) and the Behavioral Risk Factor Survey;
- Analyzing data collected from AHA community and health fair surveys of HIV/AIDS awareness, knowledge, and behavior;
- Conducting focus groups and key informant interviews of target populations as well as service providers;
- Analyzing AHA program data; and
- Conducting a stakeholder analysis.

A working group composed of employees from AHA representing several different disciplines was initially established to conduct this needs assessment. Work group members were drawn from three units at AHA—Surveillance, Prevention, and Counselling and Testing Services. Several interviewees recounted that in the past there had not been a great deal of communication among these units and that "they were excited about sharing what they were doing." A member of this group proposed that each participant in this "internal working group" collaborate with one or two CPG members to conduct the needs assessment components. Then these members would report to the CPG as a whole. However, the community preferred to steer the needs assessment process by establishing a Needs Assessment Subcommittee as one of the four ad hoc subcommittees.

The duties of the CPG's Needs Assessment Subcommittee included (1) conducting a prevention data inventory from the community, (2) performing a data analysis of current related data and presenting a summary of the findings to the full CPG, and (3) overseeing the development and analysis of the epidemiologic profile. The AHA internal working group continued to meet occasionally on an informal basis to develop a series of central questions that would ultimately drive the needs assessment process; discuss the availability of data for the needs assessment and the feasibility of analyzing it; and work on various components of the needs assessment.

We interviewed five of the eight Needs Assessment Subcommittee members. One member of this subcommittee stated that she did not see the product. Another reported that his involvement did not "entail much because AHA ended up doing all the work, ... the community did not have much input." Still another believed that old data were used and, more importantly, that they did not have enough time to do a good job. Nonetheless, one subcommittee member knowledgeable about local and national studies on groups impacted by HIV/AIDS, was satisfied with the needs assessment.

Responses from the CPG

A CPG member from outside the subcommittee stated that the resulting needs assessment document was good for the timeframe within which it was produced. However, he also stated that he "didn't get a true idea of need ... and would like to see a more in-depth needs assessment in the future." He pointed out that it normally takes six months to conduct a needs assessment and about the same amount of time to analyze the data.

One person felt "the overall theme was that we were rushed for time; we would deal with it after the plan." There was debate over seeking an extension and doing more work in the areas of needs assessment and prioritization. However, a decision was made through group consensus to deal with incomplete areas throughout the months after submission of the Plan and Application to CDC.

A respondent with a strong technical background seemed frustrated that many members could not understand just how time-consuming it would be to obtain solid data that would fill in the gaps in what was available as of late summer 1994. As with the epidemiologic profile, the desire for more solid data, which simply were not yet available, may have led to conflicts within the group.

Another person stated there was a need for someone to coordinate the process—a person who had a background in planning, understood the goals and objectives of the process, and knew what a needs assessment actually entailed. It was further posited that if they had a coordinator to utilize

existing data, the needs assessment would have been richer. In sum, time pressures and the need for stronger coordination were viewed as the two main difficulties in the needs assessment process.

2.2.3 Identifying Target Populations

The Focus Groups and Informer Interviews Subcommittee had a crucial needs assessment function. Based on its charge to convene and coordinate focus groups with populations affected by the epidemic, the subcommittee was to assist with making recommendations to the full CPG on ranking and targeting of populations. Although many respondents complained of insufficient time to organize the focus groups, this subcommittee carried out a number of steps. The subcommittee modified materials from the Academy for Educational Development (AED) for the focus groups to ensure standardization; identified two people (one from AHA and the other from the community) to coordinate and conduct these groups; and eventually conducted several focus groups and two informant interviews. However, the subcommittee did not have enough time to recruit members for all the groups it wished to establish (e.g., deaf, homeless, Asian/Pacific Islander [API], or Latino) or to analyze sufficiently findings from the focus groups held.

Suggested improvements include providing training for focus group facilitators and for analyzing and writing up results, as well as for conducting more far-reaching and representative recruitment of participants for the focus groups. One observer cited an example:

> "The women who participated were not the average women on the streets. The participants were not the best cross-section. There was even one woman from [another city]."

Another suggestion by one member was to do focus groups and key informant interviews for smaller ethnic groups within a broader cultural category, such as separate groups for Salvadorans, Mexicans, and other Latinos.

Despite these caveats, focus groups were conducted with African-American gay and bisexual men; injection drug users (IDUs); service providers for IDUs; African-American women (one for the general population and one for providers); gay, lesbian and transgender adolescents; commercial sex workers; teens; and incarcerated men and incarcerated women. An attempt was made to reach the API population, which resulted in two face-to-face interviews with Vietnamese persons. The topics discussed included general knowledge of HIV/AIDS transmission and avoidance; knowledge and

attitudes toward prevention, and primary source of HIV/AIDS education; risk factors and strategies to address them; knowledge of HIV/AIDS services; and attitudes toward HIV testing. The level of knowledge and awareness among groups varied. For example, African-American women were categorized as having a "basic" level of knowledge about HIV and AIDS, while African-American gay and bisexual men were assessed as having a high level of such knowledge.[1]

2.2.4 Prioritizing Target Populations and Strategies

The Program Strategies and Initiatives Subcommittee was charged with (1) establishing target population priorities, and (2) identifying the top-ten prevention strategies the CPG should consider for the District. It began its work at the same time as the Needs Assessment and the Focus Group and Informer Subcommittees. Rather than wait for all of the data from these groups to be supplied, the Program Initiatives and Strategies Subcommittee first filled in some gaps in information by conducting a resource inventory that listed prevention programs currently available in the District. This explains the apparent overlap among the three subcommittees, when in fact they each accomplished different aspects of the tasks of assessing needs and identifying target populations.

The Program Strategies and Initiatives Subcommittee listed populations and weighted them using CDC guidelines and materials from AED. In addition, members of this group reportedly used the epidemiologic data and their own experiences to complete this process. Subcommittee members described the process of weighting populations using the series of exercises supplied by AED that include the size of the population, HIV seroprevalence data and the number of AIDS cases. The subcommittee agreed that population size was most important and should be most heavily weighted, although in retrospect one active member was debating whether other criteria should have been considered more strongly.

The resource inventory assisted the subcommittee in identifying gaps in services, even though members found the findings somewhat inconclusive. This inventory was one input into the ranking of services or interventions. Members believed that the subsequent ranking of those services was indeed very close to the way the interventions were eventually funded.

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[1] DC HPCPC & AHA. *Comprehensive Prevention Plan for the District of Columbia.* October 3, 1994. pp. 43-57.

The Program Strategies and Initiatives Subcommittee was the largest of the subcommittees. The members seemed more satisfied with the product they produced than did respondents from other subcommittees. We interviewed four of the fourteen members of this subcommittee and noted a great deal of consistency in their responses. They seemed confident that their rankings were accurate and were arrived at through a valid process. With regard to process, respondents felt that members within their group became increasingly appreciative of each other's experiences.

The subcommittee had an active chair. When a conflict arose, members discussed it until a consensus was reached. From late August through September, members met three or four times a week, a schedule that may have brought people closer together, even though not all members could attend each meeting (and alternates were sent when necessary).

Response of the Full CPG

The prioritization process was accepted by the full CPG, but not without dissension. Gaps were recognized within the target populations and proposed interventions. Interviewees from other subcommittees addressed the concern that the numbers used in the prioritization process were flawed. For example, the group "gay white men" was ranked as number 16 out of 22 target groups, causing debate among committee members, due to the belief by some that this ranking was too low.

The overriding feeling among the group as a whole was best encapsulated by one respondent who declared, "For the numbers and things that they had, it was great." However, that still did not change their belief that a higher rating could mean access to more funding, even though it was stated forthrightly that other factors would be involved in the funding process.

Whenever possible the Program Initiatives and Strategies Subcommittee had used published indices and other quantitative data for estimating population size. However, some CPG members questioned whether it was possible to obtain accurate estimates for some populations, such as the deaf or the chronically mentally ill. Therefore, the Plan states that the tables presented in the document "should not be the only criteria used to determine funding for a specific population."[1]

One member would revisit the populations selected for prioritization. He would have begun with broad groups such as women, men who have sex with men, substance abusers, adolescents, and

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[1] DC HIV CPG, *Comprehensive HIV Prevention Plan for the District of Columbia*, October 3, 1994, p. 131.

the general population. Then, he would look for overlaps within these groups, "instead of using 20 different populations."

Clearly, time was a major stressor throughout the development of the Plan. Many believe that lack of time was further exacerbated by a lack of coordination between the subcommittees.

> "There was no consistent thread running through the process. People were overwhelmed. They just wanted to get all of the information down."

This observation is underscored by the fact that the Program Strategies and Initiatives Subcommittee was unable to obtain all necessary information from other subcommittees prior to conducting the ranking process.

2.2.5 Planned Interventions for Target Populations

After target populations were prioritized, intervention strategies were ranked for the populations. This was also a task of the Program Initiatives and Strategies Subcommittee. Once accepted by the full CPG, the prioritized populations and strategies became a part of the Comprehensive Plan. A motion was made at the full CPG meeting to change the ranking presented by the subcommittee from "high (1)," "middle (2)," and "low (3)" priority to "highest (1)," "very high (2)," and "high (3)." This suggestion was accepted because it reinforces the seriousness of the epidemic for all populations.

Each proposed strategy is presented in the Plan with a rationale, largely drawn from published literature, along with a list of target populations for whom each strategy should be geared (see Table 4). In many cases, strategies are not seen as stand-alone activities. For example, it is recommended that, where possible, condom and barrier distribution or distribution of informational materials be combined with interventions such as counselling. Street outreach may serve as a method for connecting persons who do not frequent traditional sources of health care or drug treatment with sources of HIV prevention or intervention.

Once the priorities and strategies were established, AHA was in a position to formulate its FY 1995 goals and objectives. These are presented alongside the CPG's recommendations in the Comprehensive Plan. Table 5 restates the overall goals and Table 6 presents a summary of the CPG recommendations.

Table 4. Prioritized Strategies for Target Populations[a]

Strategies	Target Populations
HIV Prevention Counselling and Testing (C&T)	IDUs/Substance abusers; African-American heterosexual women; African-American gay/bisexual men; Homeless; People living with HIV; Latino/API/gay/bisexual men; CSWs; Youth; Low income; Ex-offenders; African-American heterosexual males; Incarcerated; Latino/as; White gay/bisexual men; CMI; White heterosexuals; Disabled; Lesbians
Street Outreach and Referral	IDUs/substance abusers; Homeless; CSW; Youth; Low income; Ex-offenders; Latino/as; White gay/bisexual men; White heterosexuals
Psycho-educational Skills Building Groups	IDUs/substance abusers; African-American heterosexual women; African-American gay/bisexual men; Homeless; Latino/API gay/bisexual men; Low income; Incarcerated; White gay/bisexual men; CMI
Substance Abuse Counselling, HIV Education, Needle Exchange	IDUs/substance abusers; Homeless; Latino/API gay/bisexual men; Youth; Low income; Ex-offenders; African-American heterosexual men; Incarcerated; Latino/as; White gay/bisexual men; CMI; White heterosexuals; Disabled; Lesbians
Support Counselling Phone Line	African-American heterosexual women; African-American gay/bisexual men; Deaf; White gay/bisexual men; Lesbians; People living with HIV
Peer Education/Role Playing	African-American women; African-American gay/bisexual men; Latino/API gay/bisexual men; Youth; Ex-offenders; Incarcerated; Latino/as; API; Deaf; White gay/bisexual men; White heterosexuals; Disabled; Pediatric
Condom/Barrier Distribution	IDUs/Substance abusers, African-American women; African-American gay/bisexual men; Homeless; Latino/API/gay/bisexual men; CSWs; Youth; Low income; Ex-offenders; African-American heterosexual males; Incarcerated; Latino/as; Deaf; White gay/bisexual men; CMI; White heterosexuals; Disabled; Lesbians
Distribution of HIV Informational Materials API	Latino/API gay/bisexual men; Youth; Incarcerated; API; White gay/bisexual men
Mass Media	Youth; Low income; African-American heterosexual males; Incarcerated; Latino/as; White gay/bisexual men; White heterosexuals; Pediatric
Community Organizing	African-American gay/bisexual men; Latino/API gay/bisexual men; White gay/bisexual men; Deaf; Women

[a] DC HPCPC & AHA, *Comprehensive Prevention Plan for the District of Columbia.* October 3, 1994. pp. 135-142.

Table 5. Goals and Objectives[a]

- Continuation of a Comprehensive AIDS Training Initiative (CATI) to include a Training of the Trainers (TOT) Programs and new manual.
- Provide community presentations to diversified audiences, including PWA Speakers with expanded use of media.
- Use a multiple-strategy approach to expand the HIV Prevention Youth Initiative.
- Facilitate and coordinate an IDU/Substance Abuser Initiative.
- Develop new programs for African-American women, especially those with low incomes, and continue presentations for incarcerated women.
- Initiate a nightclub and health spa initiative.
- Launch an HIV prevention media program—both targeted and general.
- Maintain contract and grant management for the Division of HPS' 15 funded activities.
- Commit the Counselling and Testing Services (CTS) Division to reaching target populations in the epidemiological profile.

[a] DC HPCPC & AHA, *Comprehensive Prevention Plan for the District of Columbia.* October 3, 1994. Section IV A, pp. 143-167.

Table 6. Highlights of Recommendations of CPG for District HIV Prevention and Education Goals and Objectives[a]

- Intensify efforts tailored to heterosexual African Americans, with special attention to adolescents and young adults.
- Interpret the leveling trend in AIDS incidence among gay and bisexual men with caution, such that this group remains "high in the prevention agenda with initiatives specifically tailored toward Hispanics and African Americans."
- Improve data gathering efforts for smaller ethnic communities such as Asian and Pacific Islanders (APIs) and Hispanics.
- "When HIV reporting improves, HIV prevention initiatives can be maximized."
- Build an evaluation component into all District and federally funded local HIV/AIDS prevention and education components.
- "Work to change social and peer group behaviors."
- Remain cognizant of co-factors to high-risk behaviors.
- Integrate prevention efforts with already existing services (e.g., community health clinics, CTS centers, STD clinics, high-risk pregnancy programs).
- Develop family-centered education and skills building interventions.
- Improve access to primary health care (including school health, contraceptive care, and STD treatment) and substance abuse services.
- Incorporate an holistic approach into prevention messages.
- "AHA should facilitate accessibility to underrepresented communities" (e.g., the deaf, the physically and mentally challenged, adolescents, and the non-English speaking).
- Develop HIV prevention capacity-building strategies with CBOs.

[a] DC HPCPC & AHA, *Comprehensive HIV Prevention Plan for the District of Columbia.* October 3, 1994. Section VI B, pp. 169-172.

Table 6. Highlights of Recommendations of CPG for District HIV Prevention and Education Goals and Objectives (cont.)

- Collaborate with religious organizations "to coordinate a District-wide HIV prevention and abstinence campaign for youth."
- Develop a District-wide HIV prevention, education, and risk reduction plan annually, with "measurable goals and objectives," in collaboration with the PCPC.
- Deliver "appropriate HIV/AIDS education and training" to all DC government employees, including teachers.
- Mandate a human sexuality curriculum for all DC public school students, from grades 1 through 12, that will include "comprehensive HIV/AIDS education and prevention strategies, including abstinence."
- Develop prevention materials for people with low literacy, for youngsters and adults in the criminal justice system, and for specific ethnic communities (e.g., Latino, API, Native American).
- Work to ensure that "outreach workers reflect the diversity ... of the various populations of the District."
- Establish "an open, equitable, and competitive 'Request for Applications' process."
- Provide "up-to-date information" to the business community through a "public-private sector initiative."
- Sponsor peer training programs in "partnership with the religious community."
- Require that health care workers obtain continuing education in HIV/AIDS prevention and education for licensure requirements.
- Design data collection systems to reflect all racial and ethnic classifications, as part of efforts to identify and collect information on currently underrepresented populations (due to ethnicity, age, disability, or other characteristic).

2.2.6 Member Responses to the Comprehensive Plan

Most, but not all, interviewees did not see new strategies in the Plan. Some comments characterized interventions as "vague" or "weak," cited lack of attention to all of the District's ethnic populations, and expressed concern that old data were used to develop the Plan or that the interventions emphasized—such as counselling and testing services or training of trainers—were not innovative.

Several other respondents took a long-term perspective, with one expressing a vision whereby representatives of CBOs and local services will come together to develop new strategies. Another saw the community planning process as enabling participants to bring in "new perspectives, but nothing new is planned yet." Two respondents pointed out that the compressed timeline precluded developing new interventions. It is hoped that "in the implementation phase, we will get an opportunity to try out programs." The timeline also precluded researching new strategies, including considering cost-effectiveness studies.

Where members cited specific strategies to be strengthened in the future, they are reflected in the current Plan (see Tables 4 through 6). These include a project for women living in public housing, needle exchange along with outreach for testing and other services, targeted education and media campaigns, and more AIDS ministries. One new project will be culturally appropriate outreach at bars serving the Latino community.

A respondent pointed out that District-supported needle exchange programs are new since a law was passed by the DC City Council in the Fall of 1994 that expanded these programs. However, another respondent (and minutes) noted that implementation of the program has encountered bureaucratic difficulties, outside the control of AHA or the CPG. The frustration of dealing with bureaucracies was echoed by another person, who cited specific examples as a service provider. This is one reason she believes it is "hard to know if programs will be improved."

A health department respondent described a recent competitive process for $300,000 worth of grants. In order to qualify, applicants had to base their proposals on the strategies cited in the Plan and target them to one or more of the priority target populations. Unfortunately, the District's fiscal crisis was impeding award of these funds as of January 1995, even though AHA was careful to commit these funds in 1994 instead of 1995.

Sensitivity of the Plan to Cultural Groups, Women, Families, and Youth

Member assessments of the sensitivity of interventions to particular populations were fairly positive, when they were familiar with the Plan, as shown in Table 7. Some of the favorable responses were based on the reasoning that since members of a group were present, then their needs were being met. One person felt there was a lack of sensitivity to women's needs because the majority of members were male. One interviewee stated that lesbians did not receive attention as a target group in the Plan. On the other hand, people outside of a target population were seen as being sensitive to others. For example, to the knowledge of respondents, although no HIV-infected women served on the CPG, other members were apparently strong advocates for their needs. Members pointed out the need for some refinements to enhance sensitivities to families in general. Suggestions include more attention to the needs of youth, caregivers, and single men raising families. The latter two were cited as forgotten populations by individual respondents, while the first was a more general concern.

Table 7. Perceived Sensitivity of Interventions to Cultural and Linguistic Groups, and to Women's Needs

Are proposed interventions ...	Yes	Somewhat	No	DK/NS/NA
Culturally Sensitive?	6	4	2	2
Sensitive to Women's Needs?	5	3	1	4

A problem was noted where gender and culture cross-cut each other. For example, outreach and condom distribution strategies that are very straightforward may not work with Latina women. Overall, though, the feeling of many active participants is summed up by a statement that in the timeframe given, the CPG did "a good job."

Section 2.3 below will detail the constraints under which the CPG labored, how they coped with these constraints, lessons learned, and advice for others. Then, we will discuss the community response, along with some thoughts on how to define community in the context of HIV prevention planning.

2.3 Barriers and Solutions

In this section we will further detail the dynamics of the Washington DC HIV Prevention Community Planning Group. We will explore some of the major issues that emerged during the summer and autumn, as well as ways in which the group and its leadership dealt with these issues. We will also share insights the respondents developed regarding improving the community planning process for themselves and for other groups.

2.3.1 The Timeline

The October 3 deadline for submission of the Plan and Application was a driving force for the entire process. While many respondents felt that the compressed timeline created bonding among the active members, only three felt that the brief span of time from convening the CPG until submission of the Plan was appropriate. These three respondents did not think that any more work would have been done with more time, and one pointed out that HIV is an emergency so it is necessary to work as quickly as possible.

While it was recognized that a compressed timeline was crucial, the deadline for this process was characterized as highly stressful, "dramatically affecting" everything they were able to do. One person remarked, "Time was our biggest enemy [so we] didn't want to reinvent the wheel." This comment shows that the CPG strove to avoid duplicating work. On the other hand, CPG members experienced frustration at not being able to complete tasks. For example, as seen in Section 2.2 above, there was not enough time to explain the epidemiologic profile fully to the satisfaction of all members. Lack of time also necessitated using abbreviated methods to complete the needs assessment.

The compressed timeline also meant increasing the number of meetings per month. Ironically, this resulted in using valuable meeting time to revisit the issue of convenient meeting times; this was a difficult point because members were being called upon to be away from their jobs or to find alternates who could vote by proxy. Aside from subcommittee meetings, in July and August, three meetings of the full CPG took place; in September there were five such meetings.

One interviewee stopped attending meetings altogether because of the "hectic" schedule. Another was disappointed that his job precluded his being active in subcommittee work, although he seems to be a thoughtful and vocal participant at full CPG meetings.

> "I'm constantly having to assess the appropriateness of being on the Committee due to my time constraints. ... [We] came in with an incredible crunch—now it is beginning to chill out. My hope is that it doesn't chill out too much, but [I] would like to get out of crisis mode."

Plans for involving the community as a whole were largely put on hold, with the exception of a September 28 Town Meeting, which was well attended. The following observation was made by a member:

> "A general comment is that we were able to accomplish a great deal, but it was not community-driven; it was funder [CDC]-driven. We were not able to focus on what we would like to be doing. We were responding and reacting to mandates. Our approach was to take the tools and assessment of what has been done. The Committee was not in tune with the community."

Obviously, the main suggestion was to allow for more time. One person stated that creating a five-year plan should take one or two years. A very active participant recommended starting the focus group and informant interviews in the spring and then spending the summer doing the ranking process.

The impact of the timeframe, as evidenced by the comments of respondents, can be summarized as follows:

- It constrained the group's ability to complete tasks necessary to develop a complete and innovative plan.
- It constrained full participation by all members.
- It exacerbated some intragroup tensions.
- It constrained the government's and the group's follow-through on methods for bringing in the community as a whole.
- On the positive side, dealing with pressure may have created a greater sense of cohesion within the group.

2.3.2 Purpose of the Prevention Planning Group

The CDC Supplementary Guidance provides the following definition of HIV Prevention Community Planning:

> "an ongoing process whereby grantees share responsibilities for developing a comprehensive HIV prevention plan with other state/local agencies, nongovernmental organizations, and representatives of communities and groups at risk for HIV infection or already infected."

Despite an extremely high level of commitment, many participants stated that they did not have a clear sense of the purpose of the CPG. Even so, interview data coalesced around three purposes the first two of which are close to published guidelines. Those purposes are:

- Produce a product, the Community Plan, through involvement of representatives of affected communities.
- Act as an advisory body to AHA regarding HIV prevention.
- Provide monitoring and oversight of HIV prevention activities.

By and large, members were not aware of having been told the purpose of the CPG, even though the Plan states that CDC staff attended the first meeting and "outlined the mission of the community planning committee."[1] Some said that the purpose emerged over time or that it was evolving. One or two thought it must have been stated at orientation, but they could not remember what was said or written. Another person said the purpose had been stated in the nomination invitation as well as the orientation. Her statement of purpose was:

> "An opportunity for the HIV/AIDS community (both people living with AIDS and service providers) to dialogue with the AHA staff and also to be involved in decision making on the needs of the community."

Some members combined themes or emphasized process over product, as in a "collaborative effort of a community or government agency to strategically plan." Others formulated the purpose based on their experience of what actually happened: "prepare a study where the needs and

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[1] DC HIV PCPC and AHA, *Comprehensive HIV Prevention Plan for the District of Columbia,* October 3, 1994, p. 183.

demographics [would show] where the money would best be put to use and how to approach the community issue."

Perhaps the vagueness of some respondents was not due to lack of information but rather to too much information: "[At orientation AHA] gave us a big book with a lot in there, but they never clearly stated our goals and purposes." This meant that members spent meeting time wondering, "What are we supposed to be doing?" This person felt that simply estimating target populations could have been the CPG's main objective.

Not everyone agreed that there was a lack of direction in this area. A very active member stated that AHA gave the role of the CPG as groups brought together for the goal of planning. While it was clear to her that the CPG would not have oversight, she felt that she would "like to see more reports on accountability," and that the CPG should be more involved in implementing programs. A similar belief was voiced by an activist who saw the purpose of the CPG as prioritizing interventions. However, this member would like to have a more proactive role in terms of dealing with general prevention issues in the District: "I thought that we would be monitoring, but we are not. We put together a plan, but what about implementing it?"

The conflict over purpose, and perhaps some of the underlying confusion, may be due to one vision of the CPG as an advisory body to the government and another that would like to see the CPG as a monitoring body. However, some interviewees, both government respondents and community members, voiced concern over the inappropriateness of a body composed mainly of service providers deciding which service organizations get which funds.

One view expressed by AHA was that the focus of the CPG "should be on developing effective programs to address target populations and helping AHA and programs to make sure that they are effective." It was also suggested that, as an advisory group, the CPG would be in a position to lobby. Thus, government and community views were not as divergent as first appeared. Both saw the primary purpose as planning; they agreed that the CPG has a role in seeing that policies are implemented and effective and that constituencies favor some type of political role. However, the divergence comes with respect to degree of monitoring.

A member developed a vision where "the collective moves the process." Battelle's observation of a meeting, in which a discussion of coping with the District's fiscal crisis took up more time than addressing the application for supplemental funding, illustrated a view that sees the CPG mission as still evolving. In this situation, the CPG voted to engage in emergency sessions in order to address

both the CDC supplemental funding and the effect of the District's fiscal crisis upon service provision.

2.3.3 Conflict Resolution

Members were unaware of particular methods for dealing with conflict, although conflict resolution was a topic at the June 1994 orientation. Compromise and use of parliamentary procedure were cited as the main mechanisms for resolving conflicts. Meeting minutes and observation reflect discussion of differing viewpoints with motions carried through use of Robert's Rules of Order.

Members expressed varying levels of comfort with conflict. One person saw the group dynamics as highly contentious but perhaps because of a "passion" born out of "caring a lot." Another felt that if a member was not speaking up it was probably because someone else was voicing that person's opinions. Several members described participants as "adults" who can talk through their differences. They reflected the opinion that "people are encouraged to say what needs to be said."

Furthermore, one person pointed out that the active participants in the CPG tend to have leadership roles in their organizations so that it is difficult for them to act as followers in a larger group.

Of the 13 members who answered a direct question as to whether all viewpoints are heard at meetings, seven responded "yes"; three thought this was "somewhat true"; "and three responded "no." It is possible that the pressure of time may have been one of the barriers to hearing everyone's views. Perhaps this barrier is best removed by simply staying with the process:

> "There are times when in order to get through the agenda in a particular timeframe, people feel cut off, but it takes a lot of patience to deal with so many people speaking. It's a learning process to hear what others say."

The two major sources of conflict have been (1) disagreement over the advocacy and oversight functions of the CPG and (2) disagreement with specific results of subcommittee activities or data. Other issues members mentioned include:

- Previous personal agendas or concerns.
- Time to develop trust.
- Pressure of the October 3 deadline.

- The mechanics of the Plan, the Application, and the letter of concurrence.
- Lack of clear channels of communication within the group and between the CPG and CDC.

Finally, it must be remembered that community planning is a new process that does not occur in a vacuum. Here is one person's summary of the pains and the promises of community planning:

> "It was much harder than we thought. I think we did the right thing. The reasons why it is so hard are due to external issues like not enough money or [local political difficulties]. It's a new role for the community and the skills are not available. It's an opportunity for 40 people to have access."

2.3.4 Conflict of Interest

The possibility of conflict of interest is inherent in a situation where service providers who receive prevention funds may also be the most appropriate surrogates or representatives of some affected populations who are difficult to reach or bring to the planning body (e.g., active IDUs, commercial sex workers, runaway youths, and the incarcerated). As such, CDC suggests methods for developing conflict of interest guidelines.[1] Also, by removing actual funding decisions from the CPG, serious improprieties are avoided.

The Working Group that established the District's bylaws for the CPG designed a *conflict of interest form* that requests information concerning funding of members' employers. According to a former member of that group, persons were selected as individuals rather than as members of organizations. He felt that this served as "an internal safeguard" to avoid use of the CPG for "jockeying for funds."

Once the CPG was established, AHA disseminated biographical sketches that emphasized the various roles and activities of members and deemphasized particular affiliations. This was seen as another way to focus on the totality of what the new member brings to the table, rather than a particular affiliation. Members concurred, telling us that they are representatives of multiple constituencies. For example, someone with personal experience with HIV/AIDS or who is an activist may also have special expertise with runaway youth or street outreach. Someone employed by an

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[1] AED/CDC, *Handbook for HIV Prevention Community Planning*, April 1994, p. 3-2.

AIDS service organization may have had previous experience with a very different affected population than the one with which s/he presently interacts.

Members clearly liked being called upon to use all of their background and capabilities. However, two points emerged:

- **Alternates.** If members represent multiple constituencies, then it is difficult to find an alternate who will represent exactly the same set of populations. (This issue is presently being clarified.)

- **Perceptions of possible role conflicts.** Despite the care taken in selecting nominees, there is a fissure due to the *perception* by some independent members that ASO employees have a financial agenda. In addition, there was a concern that members with long-standing affiliations in HIV/AIDS were not always sensitive to the group's leadership and process. (We suggest that time be set aside for team building to deal with this issue.)

2.3.5 Attendance

The commitment to a diverse membership was one of the features that received high ratings; yet, the work was accomplished by a core group. Several respondents mentioned that attendance has been a problem; minutes and interviews show that membership and attendance rules are being reviewed at this time.

Certainly, conflicting time commitments resulted in missed meetings. In addition, two instances were cited of members of smaller ethnic groups who did not feel comfortable at meetings. A respondent suggested more attention be paid to following up on people who miss meetings. Other suggestions include getting laypeople not affiliated with any particular organization involved, or tightening up on membership and attendance rules by making the orientation mandatory and including ex officio members at the orientation.

2.3.6 Training and Technical Assistance

The majority of newly appointed CPG members attended a two-day orientation in June. Most people appreciated the orientation but would have liked more time on "developing the group."

Some members found the HIV/AIDS information too basic for their needs; others said that the amount of written information was overwhelming, with one suggesting "a user-friendly summary of what was supposed to happen during this process."

As the community planning process progressed, many training needs emerged. Some needs were based on differences in members' exposure to technical information, while others were based on process needs.

In the area of public health knowledge, participants came to the group with differing interpretations of "prevention." Some members were unfamiliar with or uncertain about the difference between primary and secondary prevention. Learning about primary and secondary prevention in the ranking process was "an educational experience" for a number of members. This was important because going back to basic definitions provided a "check" for the group: "is this [intervention or] prevention?" Many believe that "any effort would be fruitless as long as infected people are not included." As another respondent put it:

> "prevention is both preventing people with HIV from passing it on to others as well as preventing those [who are uninfected] from getting HIV in the first place."

Concern with preventing reinfection of HIV-infected persons was also voiced. Other respondents felt that primary and secondary prevention is a false distinction in the area of HIV/AIDS because "the disease doesn't work that way." Overall, such discussions of meaning, while heated, were cited as fruitful.

Not many training or technical assistance sources were used for either technical or processual issues. Again, the deadline was a factor in not seeking out additional assistance. Sources that were utilized included the CDC Project Officer, who responded to calls for assistance. Occasionally, "sister" CPGs were contacted, as was a university in a nearby state. Materials from the Academy for Educational Development (AED) proved especially useful to the Program Initiatives and Strategies Subcommittee. However, one member pointed out that, with such a wealth of resources in Washington DC, the CPG should have been able to use more of this type of expertise.

Most training needs fell under the heading of process issues:

> "Practical assistance was needed in cultural competency, planning, communication, team building, clarifying roles (who do you represent?), how to balance those roles, what prevention is, what are effective interventions, and differences between individuals and groups."

Other training needs and suggestions identified by respondents are summarized in Table 8.

2.3.7 Advice, Recommendations, and Lessons Learned

Despite the many difficulties faced by the CPG, a number of features worked especially well for the group, and some barriers created valuable learning experiences. Responses to a question about what worked particularly well can be summed up in three words—commitment, creativity, and diversity. More specifically, although not in total agreement with each other, members stated that they were pleased with the following aspects of their experience:

- The nomination process;
- Subcommittees and small group work;
- The training and technical assistance that was available (especially the AED materials);
- Deemphasizing employer affiliations in the biosketches; and
- The refreshments served at meetings.

The most repeated positive feature was the general expertise of the CPG members. Whether through education, professional affiliation, volunteer work or advocacy, or life experience—and usually through a combination—their knowledge base was very high. Perhaps the feeling of the CPG, as well as the sense of the Battelle researchers, can best be captured in the statement, "Commitment was unquestionable."

We asked many respondents the following question: "If another jurisdiction were beginning to implement a CPG, what advice would you give to that group?" One respondent was quite blunt:

> "Have it be a more active process, have more people speak up, have people from other groups speak to the Committee (Group); obtain literature from other areas and kick out people who don't come."

One member spoke of the "need to be sensitive to smaller and different cities." For example, a unique feature of Washington DC is the level of in- and out-migration that must be accounted for in the reporting system. This, in turn, affects the epidemiologic profile, the needs assessment, the ranking of target populations, the prioritization of interventions, and, thus, the Plan itself.

Table 8
Respondents' Suggestions and Plans for Further Training and Technical Assistance

- Annual orientation
- Bring experts in different fields to the Committee
- Educate CPG community members about what the government does, and educate each other as to each member of expertise or knowledge
- Epidemiological concepts
- Have CDC share what other CPGs are doing
- How to verbalize one's views succinctly
- Team building
- Conflict resolution
- How prevention funds are spent in the District
- History of HIV prevention—what works and what doesn't
- The needs of IDUs
- Building trust—including discussion of racial issues

Recommendations are tied to training needs, in this case further assistance with evaluation.

> "[There is a] need to test the model—it's the first time that CDC used community planning. Maybe in two years we'll learn if there are weaknesses and strengths to the process."

Advice to others was also based on aspects that have worked well:

> "There is no need to reinvent the wheel ... [for example] find another CPG's bylaws and adjust them [to your own needs]."

A member advises other CPGs not to "give up on the process or on each other." (Respondents' advice and recommendations are summarized in Table 9.)

Despite the presence of obstacles and conflicts, many respondents had faith in the community planning process. It was not perfect, but:

> "At least there was a process for community input and to play a role. It was better than nothing even though flawed. The process developed a constituency for prevention."

A health department respondent put the Plan into a broader perspective, pointing out that it will promote prevention in general, which had been on the back burner prior to the mandate to establish community planning. "This whole process is the best thing that could have happened."

2.4 Community Planning and the Larger Community

The learning process extended to members' own knowledge of their community and the communities with which their constituencies interact. Community planning is seen as an opportunity to go beyond one's own interest group, and people appreciated the diversity of the CPG. Examples of new contacts include working with deaf people and learning about their needs; interacting with the clergy; and dealing with issues of caregivers. Members were able to learn about gaps in the system and specific contacts they had not known about previously. One person volunteered that "she learned more about politics than HIV in general; specifically, how to apply for funding."

Table 9
Advice and Recommendations from Respondents

To CDC

- CDC should strongly advise jurisdictions on how to get the recruitment message out to the larger community.
- Supplying funding for expanded advertising of the nomination process.
- Recognize that the Co-Chair is nearly a full-time job.
- Lengthen the timeline for the process.

To CPGs and Lead Agencies

- Conduct a modular orientation for different levels.
- Decide on whether all alternates should have a vote, or just alternates for PLWAs (who may miss meetings due to illness)
- Make sure everyone is an active participant.
- Use briefing papers to educate the committee on different topics.
- Exchange drafts of portions of the Plan among different committee members.
- Distribute portions of the draft Plan to affected populations or their representatives, for their comment.
- Increase CBO and private sector involvement.
- Provide early education on terminology.
- Summarize the CDC guidance and other documents.
- Follow-up on absent members.
- Increase outreach and use the expertise of the whole community.
- Establish clear channels of communication with CDC and with each other.
- Be sure that the nomination application is clear.
- Provide a clearer understanding of purpose.
- Have a list of resources in the jurisdiction at the beginning of the process.
- Upgrade statistical information.
- Learn from other CPGs.
- Pay attention to team building including a weekend retreat.
- Remember that it is not possible to accommodate everyone.

In order to allow for flexibility, CDC guidance does not prescribe exactly which community or communities within a jurisdiction CPG members are to be representing. Thus, the definition of community, or communities, is evolving along with the community planning process. In other words, is community planning about the community of service providers; of advocates; of residents of a geographical area; of the "affected" or "infected"; or of a particular racial, ethnic, or socioeconomic group? Or can a community be defined by the intersection of multiple interests among these groups? This discussion is relevant to the need to involve multiple bodies in community planning.

Members agreed that a community cannot be defined by a broad geographic entity such as the District of Columbia. Most people focused on shared interests and values, although a few added the feature of living near one another. The following incorporates many of the ideas espoused by respondents:

> "Community is made up of different communities. [There is not] only one community, not in a traditional sense. A community is a group of individuals with similarities and differences that have shared responsibilities, visions, goals, and complementary strengths and weaknesses. Your neighbor watches out for you in a community."

The majority of respondents felt that the community planning process promoted community:

> "Building community is taking place. People get to know each other. A rapport has developed for mutual respect. Good relationships have come out of this process."

A few respondents were less happy with the degree to which the CP process promoted the community concept. One person described a Catch-22 situation—he felt there was a need in the group for greater diversity without tokenism. More training and a greater understanding of other people's backgrounds and priorities would also have created a greater sense of community within the CPG.

The remainder of this section examines the link with community through three aspects: (1) the ability to involve the community beyond the CPG at the time of the case study, (2) relationships with other planning bodies, and (3) responses from our small sample of non-CPG community members.

2.4.1 General Community Involvement

The CPG bylaws address plans for extensive community involvement. This did not occur probably due to the compressed timeline. Respondents spoke of the need to implement this "two-tiered process" now that the Plan has been submitted. The two-tiered process would entail developing four community groups for (1) individuals from the general public (e.g., parents and other private citizens), (2) community groups and associations, (3) religious groups and affiliates, and (4) consortia.[1] The groups would be a way of funneling information from the core CPG to the general committee, probably meeting quarterly and on an ad hoc basis for particular issues.

Members were highly supportive of community involvement, but two expressed caution. One member brought up the need to prepare the community to participate. Another had reservations about the two-tiered structure:

> "In theory, it was a good idea, but given the lack of capacity, it would be better to put resources into strengthening the current groups."

This same member instead recommended increased advertising of CPG meetings and providing more handouts to all attendees so that it would be easier for additional people to come and participate. Another way of involving community members would be through more focus groups.

The main vehicles for community participation were the two town meetings, one that explained the nomination process and a second for the presentation of the Plan. Unfortunately, the second town meeting happened so late in the process that, as we will see, it was perceived by some community members from outside the CPG as being more pro forma than substantive. Even so, a CPG member offered the interpretation that the Plan is "a living document and that if the community were interested, their views could be incorporated."

2.4.2 Relationship with Other Planning Bodies

In the District, the Ryan White Planning Council is the main body in the area of HIV/AIDS planning, other than the CPG. The CPG includes two ex officio members who also sit on the Ryan

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[1] AHA, *DC HIV Prevention Community Planning Project Plan and Application*, February 24, 1994, p. 5.

White Council. Respondents wished to maintain the separation between Ryan White and the CPG although, as we observed at the January 12 meeting, communication between the two groups was considered to be important.

There are clear distinctions between the two bodies. Most notably, the Ryan White Council is concerned with treatment and care issues, while the CPG is concerned with prevention only. Unlike the CPG, the Council is empowered to monitor funding of HIV/AIDS services. In addition, the Council is a regional body for the entire Washington DC metropolitan area, while the CPG is solely concerned with the District proper. Even so, one respondent observed that the CPG is more diverse than the Ryan White Council.

The Washington DC CPG does not have any formal relationships with other prevention planning groups in the metropolitan area. The District is unique in that it is a solely urban entity but also part of a metropolitan area including portions of Maryland, Virginia, and northeastern West Virginia. The needs of other areas in the metropolitan region encompass many features different from those in the District. However, some explorations were made toward sending members to the CPG meetings of a nearby jurisdiction as observers.

A future idea is to work with standing committees in the District that deal with issues that cross-cut HIV prevention and other public health concerns. For example, forming a relationship with a committee on youth would be helpful to both groups.

2.4.3 Community Member Responses

Battelle conducted brief interviews with seven respondents identified either through the attendance list of the second town meeting, through persons recommended by these attendees, or through a few of the CPG respondents (see Table 1). We wished to learn more about the way in which the Plan had been disseminated, reactions of non-members to the Plan, and knowledge of the HIV prevention community planning process outside of the CPG. In order to do this, we conducted a series of key informant interviews relying on people who already had a connection to, or involvement in, HIV prevention and education.

The interviews highlighted many of the issues already recognized by members, co-chairs, and government staff and consultants. The most positive assessment came from someone who attended the most meetings but was familiar only with the epidemiologic profile portion of the Plan, which "seemed to be accurate." This respondent thought the group was diverse and had good leadership but

needed to make more effort in seeking out grassroots participation and to call on people who are not speaking up at meetings. In fact, a facilitator who is *not* a member of the group may relieve the co-chairs of the awkward task of having to cut off discussion when a member raises a personal issue. These suggestions were echoed by someone who sees the CPG as still being "in a learning mode."

A person who attended the Town Meeting gave this description:

> "At the unveiling, no one threw bottles. [It was] pretty open and interactive; probably a good sign that the CP process worked."

On the other hand, we also heard the opinion that the process "appeared to be open, but it really was not." This response was from someone who saw the Town Meeting as "[needing] more structured oral and written comments." From Battelle's reading of CPG minutes, we wonder if this perception grows out of the late date of the meeting and the extreme pressure to complete the Plan under which the CPG was operating. This was even more difficult when someone attended a CPG meeting after the Town Meeting and did not feel that his "ideas would be incorporated at that time."

Specific ideas from these seven informants for improving the CP process and the Plan were similar to several already discussed. They include greater participation by community members, such as hands-on service providers, and more networking. Implementing the additional four community groups would help meet these goals.

In general, the Plan is seen as incomplete; time constraints were offered as one reason for this. The Plan was criticized for a lack of specificity; the implementation portion needs to be "fleshed out." One respondent was very critical of the lack of a clear evaluation component. He sees this as a flaw of HIV prevention programs in general. This respondent also advocates the return to strong messages of personal sexual responsibility that would be directed to all people, including those presently living with HIV. The Plan was felt to be sensitive to the needs of women and of various cultural groups.

The controversy over the CPG's purpose is echoed by some of the outside observers. It was suggested that the CPG focus on planning, rather than dealing with policy and political issues as well. At the same time, the difficulty in involving persons without a vested interest in maintaining present services was mentioned.

Despite these criticisms, there was a general optimism about community planning. It was hoped that the HIV Prevention Community Planning Process would have an effect on existing programs, whereby "a natural consequence will be that more planning councils will be developed for

different issues." Again, though, the caveat was offered that without evaluation, one cannot know if community planning is indeed effective.

2.5 Summary—Washington DC

HIV prevention community planning is a new initiative. It is a demanding process that requires great commitments of time and energy. Without commitment on the part of CDC, local health departments, and committee members, community planning cannot work. It is primarily through this commitment that the Washington DC CPG was able to accomplish its goal of completing its Comprehensive Community Plan.

This summary will discuss several challenges that emerged during the community planning process and suggest solutions to deal with those challenges, some of which are being instituted by the CPG. It will then highlight a number of the strengths of the CPG. We suggest that these strengths may be of special interest to CDC and to other CPGs as the community planning process continues to develop.

2.5.1 Challenges

The major challenges faced by the CPG include (1) meeting the timeline, (2) coordinating within the group, (3) clarifying the purpose of the CPG, (4) attendance problems, and (5) difficulty including people from the community as a whole. In addition, respondents identified needs for further training and for evaluation.

The October 3 deadline drove the entire process. While some people felt the group developed a sense of cohesion from working together on a product, the timeline made it difficult for everyone to participate fully. It also meant that particular aspects of the Plan were not completed to respondents' satisfaction. While this was especially true of the needs assessment, many members were also unhappy about an inability to develop innovative strategies and interventions. The CPG solved this challenge by submitting the most complete document it could, with the intention of filling in gaps after the deadline.

Even within the allotted timeframe, the planning process might have been smoother had there been a clearer structure for coordination among subcommittees. Better coordination would have facilitated the timely sharing of reports among the subcommittees and with the CPG as a whole. We

suggest that each subcommittee have its own chair, as originally planned. These chairs would report to a clearly designated coordinator. Fortunately, AHA has recently been able to hire a Coordinator for the CPG.

With regard to the purpose of community planning in general and of the CPG in particular, it is important that everyone understand the degree of advocacy, oversight, and monitoring that is within the purview of the CPG.

AHA and the initial Working Group received generally high marks on their ability to draw together a diverse group of people. Yet, some people were confused about who they represent. A solution is to define the scope of each person's representation and to clarify who may be an alternate. The latter is important because of the sharp fall off in attendance; usually, only about half of the appointed members (or their alternates) attended any one meeting.

Battelle suggests exploring the possibility that the attendance problem was really a self-correction. Perhaps 42 people are too many to do the work of planning effectively. This may be a reasonable size for an advisory group with advocacy or even oversight functions, but it is worth considering whether 20 to 25 people is a more reasonable group for conducting actual planning activities. It would also be helpful to follow up on non-attenders and try to reintegrate them into the process. In addition, the use of an Executive Committee should be reconsidered, especially if the CPG believes that a smaller planning committee will harm the goal of diversity.

Many respondents were concerned about the need for more consumer participation and community involvement in HIV prevention community planning. The CPG is developing a two-tiered structure for involving the community that strikes us as particularly useful. This structure would be a way of funneling information between the CPG and the community as a whole. Four community groups representing major constituencies could become a strong base for advocacy, as well. Furthermore, additional focus groups with many more subpopulations as well as broader advertising of meetings and of the nomination process will enhance consumer participation.

As a new model, community planning not only deserves time but patience. A number of the training needs that emerged dealt with practical issues, such as increased information on basic definitions, including "prevention." In addition, assistance with team building and conflict resolution is needed. Some CPG members knew each other and had worked together in the past; others were not very familiar with fellow team members and would have liked to know more about them and the experiences that brought them to HIV prevention community planning. A solution to this challenge, being implemented in 1995, is to allot more time to training and technical assistance. Also, the CPG

should be assisted in choosing among the wealth of resources in the jurisdiction and in accessing the CDC technical assistance network.

Battelle believes that the need for evaluation of both community planning and new interventions is unquestionable. Grantees should be supported in evaluating interventions that they are responsible for implementing. We also suggest that any evaluation strategy for community planning be long-term in nature because it will be some time before impacts will be felt and outcomes can be measured. However, it is important that process, impact, and outcome indicators be developed early so they can guide any evaluation process.

2.5.2 Strengths

The local health department and the community members demonstrated a number of strengths in HIV prevention community planning. These include (1) the CPG's ability to complete the Plan on time, (2) its ability to achieve consensus, (3) the types of expertise among group members, (4) efforts to support the input of a group of disabled citizens, and (5) the fact that the planning process was a joint effort of government and community.

The most obvious strength of the District's CPG was its ability to work together and complete the Comprehensive Plan on time. While the subcommittee structure may not have been utilized as everyone wished, it was a good structure that was implemented in a rational manner. In addition, many people were willing to meet as often as necessary to complete the work.

The CPG was made up of a broad cross-section of the District, including not only representatives of target populations but also people with many types of expertise. Whether employed in the field of HIV/AIDS prevention and education or not, there was a high level of knowledge and commitment. Also, the group melded together people with differing levels of formal education. The CPG was able to reach consensus on a number of difficult issues through compromise and standard parliamentary procedures.

One of the features members felt was unique about the District's CPG was its inclusion of deaf members who could advocate for the needs of the District's large deaf community. While special arrangements may be necessary to accommodate any disabled group, such as having an interpreter for deaf members, it is apparently worth the effort to do so. Other members learned a great deal about the needs of deaf persons and the difficulties in estimating the number of HIV+ deaf persons in the

District. We hope that it will be possible to further support the participation of persons with disabilities in HIV Prevention Community Planning.

Finally, the District of Columbia's CPG is a strong joint effort of government and the community as originally intended. This strength is reflected in the membership and in the input to each section of the Plan. The members of the CPG obviously had high standards for themselves and for the Plan. The strengthening of community planning overall can lead to the further realization of these standards.

Chapter 3.0

Los Angeles County, CA

3.0 Los Angeles County, CA

This case study draws on several sources of data for information on the HIV/AIDS prevention community planning process in Los Angeles County. A document review paid special attention to (1) history and strategic planning regarding HIV and AIDS in Los Angeles County, (2) the formation of the Community Planning Group (CPG), (3) key players, (4) population diversity, (5) types of services discussed, and (6) epidemiologic information.

Two site visits included interviews with CPG members, interviews with staff from the Los Angeles County Department of Health Services AIDS Programs (AP), and observations of meetings. In addition, telephone interviews were conducted with community representatives who were not members of the CPG. A summary of the data sources (documents, interviewees, and meetings observed) is provided in Table 10.

Interviews formed the backbone of the research efforts. With the exception of the telephone interviews, all interviews included a primary interviewer, who was responsible for guiding the interview and ensuring that all relevant issues were covered, and a secondary interviewer who was responsible for taking notes. Interview notes were generated by the secondary interviewer and reviewed and amended as necessary by the primary interviewer, as well as by a third interviewer (as appropriate). Group interviews were tape-recorded, and the audio recordings were used to supplement interviewers' notes. The same iterative method was used for meeting observation notes.

Interview notes were entered into *Ethnograph®*, a text-analytical database system that enables responses to be coded according to key themes and then grouped according to those themes for analysis. To ensure inter-rater reliability, all interview notes were coded twice by the same team of two researchers. As in Chapter 2, the themes that were based on the key issues enumerated in CDC guidance for community planning provide the organizational structure for this case study report.

Table 10
Data Sources—Los Angeles County

Documents

Los Angeles County, HIV Strategic Plan for Fiscal Years 1993/1994-1995/1996, presented to the HIV Health Services Planning Council, by AIDS Program, Health Department

Los Angeles County CPG October 3, 1994 Application to CDC

State of California, Community Planning Working Group HIV Prevention Plan, October 1994

HIV Health Services Planning Council Information Packet

HIV Health Services Planning Council Bylaws

APHA Poster: Priority Areas: HIV education and prevention

CPG minutes

CPG Bylaws-mission statement

HIV Prevention Planning Epidemiology Report

HIV Epidemiology Department of Health Quarterly Statistical Reports, 1993-1994

Meetings Observed

CPG Meeting, November 1994

State of California, Community Planning Working Group Public Hearing, November 1994

HIV Health Services Planning Council Meeting, January 1995

CPG Public Hearing, January 1995

Interviews

AIDS Program Office staff members (5)

Planning Council Public Liaison (1)

Other Health Department staff members (3)

CPG members (9)

CPG community Co-Chairs (2) and AP Co-chair (1)

Non-CPG community members (3)

3.1 Background of HIV Prevention Community Planning

Los Angeles County has been engaged in planning for HIV and AIDS since the beginning of the epidemic. This section will discuss the early history of HIV/AIDS planning in the county and then discuss the initiation of the HIV prevention community planning process in 1994.

3.1.1 History of Planning in LA County

A variety of different planning bodies have been involved in HIV and AIDS community planning efforts. In order to provide the reader with the context of the local effort, the following paragraphs outline the various planning initiatives and briefly describe the different entities involved in planning.

Planning first began in 1986, when the county set aside some funds from the Health Services and Resources Administration (HRSA) Adult Demonstration Project grants for this purpose. Initial AIDS planning addressed two areas:

- Needs assessment for AIDS care and treatment services and
- Development of a strategic plan to determine future directions for care and treatment needs.

A *strategic plan*, developed by a consultant in 1988 without a great deal of community participation, made recommendations for AIDS services and treatment as well as for budget planning.

The first AIDS-related planning body in Los Angeles County, established in 1987, was the AIDS Commission, which generated the first AIDS services recommendations to the Health Department. At the time of this study, the AIDS Commission's primary purpose was to address policy issues. It is presently being consolidated with the Ryan White Planning Council. Table 11 displays the various planning bodies for HIV/AIDS in the county, along with their dates of implementation and purposes.

The AIDS Commission was supplemented in 1988 by a county Community Planning Group, whose membership grew from about 18 members to nearly 50.[1] This group addressed planning for

[1] This is not the present CPG that forms the basis of this report and was implemented in 1994.

Table 11
Evolution of the HIV Strategic Planning Process in LA County

<table>
<tr><td colspan="2">AIDS Commission (1987)

Purpose: to plan for AIDS treatment services</td></tr>
<tr><td>AIDS Regional Board (1988)

100 community-based groups. Consists of Task Forces or Caucuses representing community constituencies.

Purpose: provide community input into the Ryan White planning process.</td><td>Ryan White Planning Council (1988)[a]

Purpose: planning body for Ryan White Title I, II, III funds, and all HIV services/programs money.</td></tr>
<tr><td colspan="2">LA County Community Planning Group (1994)

Purpose: conduct prevention planning</td></tr>
<tr><td colspan="2">AIDS Commission and Ryan White Planning Council

have merged to become

The HIV/AIDS Commission (1995)

The Community Planning Group is now a Select Committee of the new HIV/AIDS Commission</td></tr>
</table>

[a] **NOTE**: The Los Angeles County Planning Council was unique among Ryan White Planning Councils. The power it had vested in it by the County Board of Supervisors gave it jurisdiction over all HIV/AIDS money, including Prevention dollars, for the community. It was felt that this would allow for a more rational strategy with regard to HIV/AIDS money coming into the community.

the whole spectrum of AIDS services, from prevention through counselling and testing to treatment. This initial Community Planning Group was succeeded by the Ryan White HIV Health Services Planning Council, which was authorized by the county Board of Supervisors in 1990 to address planning for both treatment and prevention services in Los Angeles County. The Planning Council receives community input both from holding open meetings and from having representatives who also hold seats on the AIDS Regional Board. The Planning Council has two primary mandates:

- To conduct strategic planning for HIV prevention and treatment services for Los Angeles County, with input from the AIDS Commission and the community.
- To make funding allocation recommendations to the county Board of Supervisors for all HIV-related services.

The second planning initiative was completed in March 1990. AP staff drafted a plan with extensive community input from an advisory task force that eventually numbered 35 or 40 people. While the major focus of the Strategic Plan was on care and treatment of people with AIDS, priorities for prevention were also included. In January 1994, the Strategic Plan was updated by AP staff with input from a variety of community sources, totalling over 300 people. This version of the Strategic Plan formed the foundation of the October 1994 submission to CDC.

The present CPG, known as the Prevention Planning Committee, was created in 1994 specifically to address prevention planning in Los Angeles County. It undertook the process of community planning described in detail throughout the rest of this chapter. This process led to the development of a comprehensive HIV Prevention Community Plan incorporating the January 1994 Strategic Plan.

3.1.2 Initiation of the HIV Prevention Community Planning Process

The community planning process was initiated by staff within the Los Angeles County Department of Health Services AIDS Programs Office. Pre-planning involved AP staff and LA-based representatives of the Statewide California Prevention Community Planning Group. A subcommittee was formed to work out the details of the nomination process.

The expectations of some members of the HIV community differed from the final outcome. One CPG member recalled participating in an early planning meeting in April or May of 1994. This

meeting was convened by AP staff with the goal of implementing a process for nominating CPG members. In the words of the respondent,

> "We set up subcommittees to address specific aspects of the process and actually divided up the tasks, but none of it ever happened..... It became a unilateral county effort. They made an initial attempt to involve the community, but didn't follow up."

This respondent suggested that the "impossible timeline" faced by AP staff in putting together a CPG may have accounted for the lack of follow-up.

A key issue for AP staff in initiating the process was determining how many members should serve on the CPG. AP staff expressed concerns about having too few members, since that could preclude adequate representation of Los Angeles County's diverse communities. They were also concerned that having too many members could prevent the group from making critical decisions in a timely manner. AP staff and the three Ryan White Planning Council co-chairs determined that the CPG should optimally have between 20 and 25 members. An AP staff member stated four goals in installing the CPG:

- To ensure that members represented multiple constituencies, rather than a particular service;
- To include representatives who were experts in education and prevention;
- To bring new people into the planning process; and
- To create a group that was smaller than the Planning Council.

Member Nomination

The nomination process was conducted by staff in AIDS Programs. The initial invitation for community nominations was conducted by mail. AP maintains numerous mailing lists of AIDS service organizations, other community-based organizations (CBOs), and individuals active in HIV and AIDS in Los Angeles County. Five mailing lists, totalling about 1,700 recipients, were used for the initial mailing, which contained a letter describing the purpose of the CPG, a nomination form, and instructions for nominations. The mailing lists included individuals, groups, and organizations funded by AP, and persons not in the funding loop. Interested parties attending meetings, and signing

their names are automatically placed on the mailing. There is a vast variety of individuals from government, churches, schools, academia, and research, as well as private citizens, who form the core of these mailing lists.

Within a week following the first mailing, a second wave of letters was sent to the same 1,700 recipients. Protesters from sexually transmitted disease (STD) and AIDS Regional Board community-based task forces on education, prevention, counselling, and testing made the case that the response time was too short and the questions in the first mailing too limited to ensure full community participation. This second mailing contained a revised nomination form and a more detailed letter of information.

A number of respondents reported that the purpose of the multiple nomination mailings was not clear to members of the community. Interviewees mentioned receiving both versions of the nomination form and experiencing confusion about how to respond. Some individuals did not know which form to submit; others discarded the second form as they had already submitted the first.

Other means were also employed to disseminate information about the CPG nomination process. Announcements were made at the Planning Council meetings, and Planning Council members disseminated information to the agencies they represented. For the most part, there was agreement among the interviewees (both from AP and CPG) that the mailings were comprehensive and reached a wide variety of people in Los Angeles County. Most CPG members noted that they had heard about the CPG from a number of sources, including direct mailing as well as referrals from colleagues and supervisors. In the words of an AP staff member, "we cast a really wide net."

When asked why they applied to serve on the CPG, most members responded in terms of their commitment to HIV prevention (based in both personal and professional experiences with HIV and AIDS) and their desire to ensure that their communities or constituencies (e.g., homeless youth, Asian-Pacific Islanders) were represented. In addition, they all welcomed the opportunity to serve on a body whose sole focus was HIV prevention. This is in contrast to the Planning Council, where prevention issues are combined with (and, in the views of many respondents, secondary to) issues of care and treatment.

Member Selection

AP received 126 nomination forms in response to the mailings. Nominations were given equal consideration, no matter which of the two nomination forms were submitted. The selection process

was blinded, with both names and agency affiliations removed from the applications before they were reviewed. The applications were reviewed by six individuals: two community-based Planning Council co-chairs and four representatives from AP (one of whom is also a Planning Council co-chair). The Planning Council co-chairs and the Director of AP had final approval of all members selected, through authority vested in them by the County Board of Supervisors.

Applications were scored according to the geographic areas the nominee served; the target populations the nominee served, represented, or had experience with; and personal qualifications. The applicants were asked to address issues such as previous experience with HIV prevention and their perspectives on the most and least effective methods of HIV prevention. These answers were not scored but did receive a qualitative ranking.

AP staff expressed the strong desire that CPG nominees be able to "wear many hats." That is, nominees were chosen in part on the basis of their ability to represent multiple community constituencies. This, too, is in contrast to the Planning Council, where seats on the Council are allocated on the basis of representation of particular CBOs, regional entities, and political appointees. In addition, AP staff saw this as an opportunity to bring new people into the planning process. Because prevention issues had not been strongly represented on the Planning Council, many saw the CPG as an opportunity to hear from individuals and communities who had not been active participants in previous HIV planning efforts.

Representation and Inclusion

While all interviewees expressed confidence in the individuals that had been appointed to the CPG, their integrity and their dedication, some interviewees expressed concern that some communities were not represented on the CPG. The under-represented communities and institutions cited by respondents include the incarcerated, adolescents, lesbians, women, the school system,[1] and churches.

It is worth noting that widespread agreement did not exist about all of these perceived gaps. For example, lack of representation by an individual experienced in the health care needs of women was offered by some as a drawback, while others pointed to the number of women on the CPG and

[1] Although education was cited by some respondents as lacking representation, an advisor from the school system attends the CPG (see Section 3.2.4).

their varied experiences in addressing women's issues. Table 12 presents the characteristics of CPG members as compared to those of people with AIDS (PWAs) in Los Angeles County (which is the standard suggested by CDC).

The debate over representation speaks to a critical issue: whether an individual's ability to represent a particular population or community rests upon their membership in that community or upon their experience with that community. For example, to represent the needs of adolescents adequately, it may be necessary to have adolescents on the CPG or it may suffice to have members who have experience working with adolescents and who are familiar with their needs. As one member put it, "How can we represent anything other than our own experiences?" The CPG appears not to have been able to resolve this fundamental issue; as a consequence, the issue of representation has not been resolved. Table 13 presents the areas of expertise of the CPG members and demonstrates the diversity of experience that was the goal of AP in convening the CPG. (One member may have more than one area of expertise.)

Two interviewees were concerned that the nomination mailings targeted mainly people "in the funding loop," or at least that mailings did not reach such institutions as churches or schools. It is possible that some participants did not fully understand the nomination process, or that, despite the large number of interested parties at meetings, nomination forms did not fully penetrate all communities.

Because the issue of representation was raised so frequently, the AP staff coined a term for it: "survival guilt." The feeling was that CPG members felt guilty for having survived the selection process while others did not. Many of the CPG members were new to community planning processes and faced disapproval from more established members of the AIDS community who were not selected for the CPG. The frequent discussions of the issue at CPG meetings was seen by AP staff as a necessary process to alleviate this survival guilt. It is worth noting, however, that this term was used only by AP staff and never by CPG members themselves.

Table 12
HIV Prevention Planning Committee Members
(Comparisons of Patterns of Persons with AIDS [PWAs] in LA County)

	CPG		LA County PWAs — %[a]
	Number	Percent	
Gender			
Males	14	61	93
Females	8	35	7
Transgenders	1	4	unknown
Sexual Orientation			
Gay Men[b]	11	48	64
Lesbians	2	9	< 1
Bisexual Men	1	4	14
Heterosexual Men	1	5	7
Heterosexual Women	5	23	5
Heterosexual Transgenders	1	5	not available
Declined to State	2	9	10
Ethnicity			
White	10	43	47
African American	5	22	21
Latino/Latina	5	22	29
Asian/Pacific Islander	2	9	3
Native American	1	4	< 1
Publicly Disclosed Persons with HIV/AIDS	*3*	*13*	

Source: AIDS Programs LA County.

[a] Percentages are rounded to the nearest whole number.

[b] A reason for the under-representation of Gay Men on the CPG is that AP and the office of HIV epidemiology felt that the CPG should reflect the changing course of the epidemic.

Table 13
Target Population Expertise of
Prevention Planning Committee Members

Adolescents and Children *14 members*	African Americans *6 members*	Asians and Pacific Islanders *2 members/ 2 advisors*	Developmentally Impaired *3 members*
Families with Children *8 members*	Gay Men of Color *10 members*	Gay White Men *6 members*	Hearing Impaired *2 advisors*
Hemophiliacs *1 member*	Homeless *9 members*	Immigrants *10 members*	IDUs and their Partners *11 members*
Incarcerated *7 members*	Latinos/Latinas *11 members*	Mentally Ill *8 members*	Native American/Aleut *3 members*
Non-English Speaking Persons *8 members*	People of Color *12 members*	People with TB *5 members*	Physically Challenged *3 members/1 advisor*
Substance Misuse *12 members*	Transgender persons *6 members/3 advisors*	Undocumented People *11 members*	Women *10 members*
Women of Color *13 members*	Women with Children *10 members*		

Sources: AP listings of CPG members

Ultimately, however, the CPG members expressed confidence in their commitment and ability to represent the needs of the community. The crux of the issue may lie in the difficulty of fully representing the size and diversity of Los Angeles County with a committee of 22 individuals.[1]

3.2 Implementation of the HIV Prevention Community Planning Group

Held in the AP offices on July 7, 1994, the first meeting of the CPG was used to orient CPG members regarding their role in HIV Prevention Community Planning. All members received an orientation notebook, containing the CDC *Handbook for HIV Community Planning*, the Los Angeles County 1993 core application to CDC,[2] the Los Angeles County HIV Strategic Plan, and a summary of parliamentary procedures and open meeting requirements.

3.2.1 Committee Structure

The CPG voted to have three co-chairs, two from the community and one from AP. The co-chairs share responsibility for running the meetings; they meet one week before each meeting with facilitators from AP to develop the CPG meeting agenda, assign responsibilities, and air any issues that require resolution.

AP assigned two staff members to act as facilitators for the CPG. These individuals take care of all logistical arrangements for CPG meetings (e.g., acquiring a meeting room, obtaining audiovisual aids, and taking and distributing minutes for the meetings). They also provide support and assistance to the CPG in the development of the HIV Prevention Plan. This role includes such activities as authoring first drafts of sections of the Plan for review and comment by the CPG; assisting in the development of bylaws; and supporting the development of statements of mission, vision, and values.

As a select committee of the Ryan White Planning Council, the CPG has a distinct status, with its own structure, bylaws, rules, and processes, operating according to statewide legislation requiring

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[1] Technically, there were 23 seats, but the representative from West Hollywood had not yet been appointed.

[2] The 1994 application, due along with the Community Plan in October 1994, was a continuation application.

that meetings be public. As of late 1994 and early 1995, CPG members expressed mixed feelings about this status. Some respondents expressed a desire for autonomy from the Planning Council, while others believed that their efforts would not achieve full recognition without the formal status of a select committee. This is because the Planning Council possessed the authority to make all funding allocation decisions, including those specific to prevention.

3.2.2 Terms of Office

All CPG members were appointed for one year through August 31, 1995. Their goal is to complete the revised HIV Prevention Strategic Plan by that date. Members were not certain what would then become of the present CPG. It is likely that half of the present membership will continue through the next year. New bylaws and mechanisms for membership are presently being adopted.

Regular attendance at CPG meetings is required of all members. Missing three meetings in a row is grounds for dismissal. Policies and procedures indicate that replacements for dismissed members are to be selected by CPG co-chairs, with the agreement and acknowledgement of Planning Council co-chairs.

3.2.3 Subcommittees

Subcommittees are used by the CPG on an ad hoc basis to address particular needs or tasks that arise in the course of the community planning process. CPG members serve on subcommittees on a volunteer basis; several respondents noted that the same subset of CPG members tended to serve on subcommittees. This was attributed variously to their having more time to commit to the process than others, their feeling more comfortable working in a small group, and their desire to get things done. Subcommittees were formed to address the following tasks:

- Preparation of the application to CDC due October 3.
- Development of a survey of CBOs for the needs assessment.
- Determination of geographic areas to target in public hearings.
- Identification of target populations.
- Determination of the need to add members with different areas of expertise.
- Development of bylaws.

These working groups were dissolved after accomplishing their purpose.

One CPG member highlighted participation in subcommittee work as one of the strengths of the planning process. "The most rewarding thing for me is subcommittee work. I feel I'm able to use my own voice, and really get to participate."

3.2.4 Advisors

The CPG draws on advisors from the community to enhance their knowledge base and expertise. As one AP staff member put it, "Advisors add to the expertise in the CPG. They fill in the gaps in knowledge. They give specific information the group feels it might lack." Advisors represent the following issues:

- Epidemiology (two Health Department staff members)
- Deaf and hard of hearing (AIDS Regional Board Task Force)
- The state community planning body (State CPG)
- National policy issues (State-level person)
- Asians and Pacific Islanders (AIDS Regional Board Task Force)
- Women (Local organization)
- Transgender people (Independent)
- Education (LA School System)
- Substance misusers (AIDS Regional Board Task Force)
- Commercial sex workers (CBO)

One advisor may represent more than one constituency. The epidemiology advisors have been regular attendees at CPG meetings; attendance by other advisors varies markedly.

Advisors have been chosen by the co-chairs, though some discussion arose among CPG

members as to whether advisors ought to be chosen by the CPG as a whole. The co-chairs have suggested adding advisors, but this issue was tabled at the November 17 CPG meeting. As an AP staff member put it, "the increased use of advisors may be a way of granting favors to people or getting them a seat they otherwise wouldn't have at the table." One advisor expressed uncertainty about the function and expectations attending the role: "It's a vague role. It's not clear what their expectations are—the role has never been spelled out or defined." This view is in contrast to the fact that the role of the advisor is defined in the policies and procedures document. All members and advisors have a copy of this document in their possession. Perhaps, as seen in Chapter 2, participants are finding it difficult to absorb all the information with which they are provided.

3.2.5 Practical Assistance

AP has two full-time facilitators for the CPG. They provide interpreters for the deaf advisor and travel reimbursement. Meetings are held at the offices of AIDS Project Los Angeles in Hollywood, where the meeting rooms are large and parking is free. Meetings are held on Thursday afternoons from 2:00 to 5:00. A few CPG members expressed dissatisfaction with the meeting time because it takes them away from their workplace responsibilities.

The CPG members interviewed all held full-time jobs, so the time commitment required for participation in the CPG is an important factor. CPG members who work for small agencies representing particular communities expressed the concern that their absence from their workplace was particularly burdensome. At the same time, they felt a strong need to ensure that their communities were represented. CPG members whose work involved case management or other forms of direct service provision were acutely aware of the time constraints. As one respondent put it, "the people you are helping, the ones you have to do case management for, are still there, even if you have participated in a prevention planning meeting." A proposal for evening meetings for the CPG was considered, but was voted down.

3.2.6 Technical Assistance

According to the respondents, technical assistance has been provided through five training sessions or workshops. The requests come from either AP personnel or the CPG members or co-chairs themselves. Two sessions have been conducted by the Epidemiology Program. One session

was conducted by an expert on "the deaf community" (differently abled individuals). A third was conducted by an expert on the incarcerated; he is a member of the AIDS Regional Board, Task Force on the Incarcerated. The last session was conducted by a transgender individual, raising the issues of transgenders at risk. The sessions have been positively received. Everyone interviewed felt that the sessions were "very informative," "well done," "very good," "very educational."

Technical assistance was also provided around issues of protocol. An AP staff member noted that "members are reminded about Roberts Rules and the Brown Act and how to conduct themselves in a meeting."

The third form of technical assistance was that provided by CDC. A co-chair who attended the technical assistance meeting in Atlanta in August described it this way:

> "At the Atlanta meeting, maybe 10 percent of the people there were gay; maybe 15 percent were people of color. Most were from health departments. Most of the meeting was technical assistance on how to complete the application. LA was more advanced than most because we had the advantage of the existing three-year strategic plan. They provided us with a lot of information and told us who to get information from."

When asked what was most useful about this session, the co-chair remarked, "It made me appreciate where LA is at versus other states. We're doing a lot more right than most states." A co-chair reflected that CDC needs to provide: "A better explanation of what's expected of us, what they wanted, what the purpose is, what the process is all about."

3.3 Development of the Community Plan

This section focuses on the epidemiologic profile, the needs assessment, and the identification of target populations. It will also briefly discuss ongoing efforts to address gaps in the Plan.

3.3.1 Background

According to the Bureau of the Census (1994, Statistical Abstract of the United States), California is the most populous state in the United States, ranking second in terms of residents living in metropolitan areas and third in terms of birth rates. These rankings are projected to continue past

the year 2000, making the population of California one of the fastest growing in the nation. California is one of the most diverse states as measured by ethnic make-up, with approximately 57 percent of the population white, 27 percent Latino, 9 percent Asian/Pacific Islander, 7 percent African American, and less than 1 percent Native American. Los Angeles County is the largest California county, with Los Angeles the largest city.

The County of Los Angeles is an area that encompasses 4,004 square miles; it covers 88 incorporated cities and has 26 health districts under its jurisdiction. According to the 1990 census, Los Angeles County is the most populous county in the US, and the diversity of its population mirrors California's. Its population is approximately 41 percent white, 38 percent Latino, 10 percent African American, 10 percent Asian and Pacific Islander, and less than 1 percent Native American. Los Angeles County accounts for 36 percent of the AIDS cases in the state of California.

3.3.2 Epidemiologic Profile

The epidemiologic profile used in the Plan was created by two members of Los Angeles County Department of Health Service's HIV Epidemiology Program. These two individuals, the director of the Epidemiology Program and the director of the Surveillance Unit, are advisors to the CPG. The HIV Prevention Planning Report is still used for identifying target groups and will influence the prioritization procedure. The HIV Epidemiology Program was involved in the CPG process by AIDS Programs staff. They were asked to contribute to the prevention planning process by putting together an epidemiologic profile.

Those staff interviewed were glad to be part of the CPG process. They felt a fundamental commitment to the process and were determined to see that "they would be an independent source of data" for the CPG. "We don't have an agenda based on politics or interests," noted the epidemiology group. They felt that they wanted to "help people understand and interpret the epidemiologic data."

The Epidemiology Program provided data to policy-setting groups in Los Angeles prior to their participation with the CPG. Their first experience with policy-making bodies was providing data to the Public Health Commission followed by the AIDS Commission. The Epidemiology Program created a summary report for the CPG and worked on the report for six weeks. "It was a dynamic process," said the epidemiologists. The draft document was reviewed by the CPG. When the presentation on the epidemiologic profile was made to the CPG, "there were a lot of good questions,"

and the epidemiologists felt that the process made them consider the epidemiological data in different ways than they had previously.

Information Sources

Multiple sources of data were used for the epidemiologic profile. The information sources included AIDS and syphilis surveillance data; data from CDC unlinked seroprevalence studies in Counselling and Testing (C&T) sites, public TB clinics, public sexually transmitted disease (STD) clinics, drug treatment centers; a survey of childbearing women; data from IDUs not in treatment; and a clinic serving the homeless.

Staff based the profile on AIDS surveillance data because "this is the best population-based data source," and these data are "the starting point to understand the more important epidemic of HIV." The seroprevalence data have multiple sources, most of which are clinic-based data collected through CDC-funded sentinel clinic or population studies. The clinic-based data for LA County came from sexually transmitted disease clinics,[1] TB clinics, clinics that served women of child-bearing age, and clinics serving the homeless and runaway or homeless youth.

Other surveillance data came from drug treatment clinics, TB clinics and TB control data, and the County Hospital in Los Angeles. LA County also has CDC Sentinel Hospital data and seroprevalence data from military recruits. There are 60 to 120 counselling and testing sites in the County, some of which offer anonymous testing services. These data are used in the profile, but they can be hard to interpret. With regard to drug users not in treatment, the best data come from the STD clinic data. One seroprevalence study using community outreach to target drug users was also used in compiling the profile. Another study of IDUs out of treatment has been implemented and will be used in any update.

After looking at the seroprevalence and seroincidence data, it was felt that more behavioral information was needed. More than three years ago, RAND did two surveys of behavior and health care utilization in Los Angeles, including a set that contained knowledge, attitudes, and practices regarding sexual behavior and AIDS. One survey oversampled the African-American and Latino

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[1] Data sources included the syphilis and gonorrhea surveillance data from the STD clinics. There were over 110,000 STD clinic visits over the last year at 34 sites.

communities, while the second was mostly focused on white gay men in the Hollywood and West Hollywood areas. These data were also used in the profile.

Brief Overview of the Profile

The epidemiologic profile not only served to summarize the AIDS case data for the CPG members but looked at seroprevalence and seroincidence data as much as possible. The profile also served to summarize trends over time in AIDS and HIV data that the Epidemiology Program and Sexually Transmitted Diseases Department had collected. This section will contain a brief summary of the HIV Prevention Profile, starting with a summary of AIDS case data, looking at the HIV seroprevalence data, and describing trends over time.

Table 14 shows cumulative AIDS cases in the Los Angeles County area through mid- to late 1994, compared to the AIDS cases in California and the United States. This table serves to illustrate some of the trends in AIDS case data in LA County and shows how they differ across California and the United States. Briefly, men account for a higher percentage of cases in Los Angeles County than in the U.S. Latinos account for a higher and African Americans for a lower percentage than in the U.S. data. The differences are likely due to the differences in the racial/ethnic distributions of populations of Los Angeles County and the U.S.

A difference is also seen in the HIV risk profiles of persons with AIDS in Los Angeles as compared to national data. A greater percentage of Los Angeles County cases are associated with male-to-male sexual contact than with injected drug use than the national data show.

Nearly 87 percent of AIDS cases in Los Angeles County were diagnosed in persons 20 to 49 years of age. Given the latency period of AIDS, this indicates that most infections are occurring among persons less than 40 years of age. Seventeen (17) percent of the cases were reported to be in those aged 20 to 29 years, suggesting that they were infected during adolescence.

The rest of the discussion in this section concentrates on trends that the epidemiology advisors presented as part of the HIV Prevention Planning Report. The report presented trends of HIV and AIDS case data showing changes across time spans of three to eight years. Briefly, the trends showed that Latinos account for an increased proportion of HIV/AIDS in LA County; but AIDS rates among African-American men and women are highest and increasing most rapidly.

Table 14

Cumulative Adult AIDS Cases in Los Angeles County, California, and the United States

	Los Angeles (Sept. 1994)[a]		California (Sept. 1994)[b]		United States (June 1994)[c]	
Category	**N**	**%**	**N**	**%**	**N**	**%**
Male	25,546	95	73,766	96	344,776	87
Female	1,415	5	3,074	4	51,235	13
Latino	6,491	24	13,063	17	56,988	17
African American	5,025	19	11,526	15	99,502	29
White	14,805	55	50,714	66	184,496	54
Asian/Pacific	472	2	1,536	<2	2,411	1
Islander	57	<1	159	<1	789	1
Native American						
Gay/Bisexual	20,354	75	59,167	77	211,779	53
IDU	1,727 [d]	6	5,379 [d]	7	98,367 [d]	25
Gay/Bisexual IDU	8,849	7	6,147	8	25,447	6
Heterosexual	751 [d]	3			27,281 [d]	7

[a] LA County DHS, *HIV Epidemiology Report*, October 1994.

[b] CPWG, CA *HIV Prevention Plan*, October 1994.

[c] CDC, NCPS, *HIV/AIDS Surveillance Report* Vol. 6 No. 2.

[d] Includes males and females

AIDS rates are lowest among Asian/Pacific Islanders but with substantial variation by country of origin; Thais show the highest and Koreans the lowest rates. Males show that they predominantly contract HIV from same-gender sex, but there is variation by racial and ethnic groups. Asians and whites show over 80 percent of male cases acquired through this mode of contact, Latinos about 73 percent, and African-Americans about 65 percent. In contrast, injected drug use as a risk factor is greater for African-American men (13 percent) than others (Latinos at 7 percent, whites at 5 percent and Asians at 2 percent).

The most interesting finding showed geographic changes in prevalence of HIV/AIDS, with the trend moving into more African-American neighborhoods than at the start of the epidemic. Another important trend described HIV/AIDS generally following along the lines of neighborhoods, with the most heavily affected neighborhoods being the low-income neighborhoods—independent of the racial and ethnic make-up of those neighborhoods.[1]

Difficulties in Obtaining Information

The Epidemiology Program staff believed the quality of the AIDS surveillance data in Los Angeles County was very good. However, it was generally agreed that, although the epidemiologic data were good, the behavioral data are lacking.

Some CPG members complained about the "target" group focus. A couple of interviewees mentioned that they should be looking at "behaviors" rather than at "target groups." They felt that, especially for prevention, one has to look at how people are behaving. One person said that the Plan in San Francisco should be used as a model, because "they are targeting behaviors; that is, they are looking not at who you are but what you do." However, most health department personnel and CPG members interviewed agreed that the target groups were a "guide," and in fact were subject to change. One person said, "I won't be surprised if they were different, we *anticipate* differences."

A subcommittee of five members has been established to go through all the data from the epidemiology report, application and Strategic Plan and reach an initial decision on the target groups. The subcommittee will make recommendations to the CPG, and discussions will be held regarding finalizing the "target groups." The LA CPG has yet to go through this process.

Reaction of CPG to Information

All the above data were used in putting together a 25-page report that was presented to the CPG. The report contained written summaries and tables to illustrate the trends in HIV/AIDS in the Los Angeles County area. The process was iterative in that the Epidemiology Program initially presented a draft document and also attended the CPG meetings to present the data visually to the

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[1] AIDS Programs. *Application to CDC.* October 3, 1994, Los Angeles Department of Health Services, pp. 12-13.

group and allow CPG members to ask questions about the epidemiologic data. The Epidemiology Program respondents said that the CPG members asked "very good questions" during the meetings and that the meetings were very interactive with a high level of interest shown by CPG members. They mentioned that members seemed very motivated to understand what it was the epidemiological data could show them. In fact, one individual said that by the end of the process they felt that the "group had a good understanding of both the strengths and drawbacks of the epidemiologic data."

General consensus was observed among all interviewees (both AP and CPG) that the epidemiology reports and the data presentations were "extremely useful," "very well done," and "as clear and understandable as they could make it." In fact, a few CPG interviewees stated that they found the data so useful they were sharing it at their workplaces, among other individuals in HIV/AIDS service organizations, and between organizations or task forces of the AIDS Regional Board.

Other departments within the health department exhibited positive feelings about the CPG epidemiologic profile and the fact that the CPG process had given AIDS Programs personnel a chance to work closely with the Epidemiology Program. It was felt by both the AP and the Epidemiology Program that the chance to work so closely together was a "luxury that didn't happen often enough." Everyone in the health department thought it was a very valuable experience. AIDS Programs personnel exhibited a strong commitment to ensure that the process of setting target groups and prioritizing was "data based," and that commitment was reinforced by the careful work the Epidemiology Program put into compiling the HIV Prevention Planning Profile.

Although the report was well received by the CPG members, their interview responses expressed frustration with the data presented. The major focus of the CPG members' frustration was that "AIDS cases reflect the past" and that somehow all the HIV prevalence, seroincidence data, and AIDS case data "were leaving affected groups out." The groups that the CPG felt were "left out" included women and minorities (people of color) who might be misidentified by race or ethnicity or who might exist in cultures where the ethic of privacy is so strong that individuals die without ever being identified as having had AIDS. In addition, there was some feeling that for very disenfranchised groups, such as transgenders, the health department had *no* good data.

A perception manifested itself among CPG members that the summary of the RAND report was only on one target population (gay white men), even though a survey had been done that oversampled African Americans and Latinos. Members were frustrated by a lack of "behavioral data overall." As one of the CPG members said, "Prevention is forward looking; we have to make

decisions about groups that are likely to be affected." They felt this would be difficult to do given the retrospective nature of HIV seroprevalence and seroincidence data and the extremely retrospective nature of AIDS case data. A few CPG members flatly stated that they felt as though they had gotten "*no* behavioral data."

Health department interviewees also recognized that the data had shortcomings. They felt that "good behavioral data on individuals' sexual and drug habits *was* lacking." The epidemiologists felt their epidemiologic data was as good as it could be but also acknowledged data gaps regarding individuals' behaviors.

3.3.3 Target Populations

The identification of target populations that appear in the prevention section of the Strategic Plan (a modified version of which was submitted to CDC in October 1994) was an iterative process involving AP staff and community members. Though much of this work was conducted before the present CPG was convened, it provides useful insights into one of the fundamental tensions in the community planning process.

AP staff had originally intended for a community-based organization, the AIDS Regional Board Education and Prevention Task Force, to identify target populations for the Strategic Plan. The Task Force conducted a week of hearings at the Gay and Lesbian Community Center and heard testimony from numerous AIDS service and prevention agencies. An AP staff member described it this way:

> "It was an innovative way to get the data—it's just what they did with it that's a problem. Basically they got a lot of agencies coming in and talking about what would happen if they lost funding, plus some representatives of population groups talking about unmet needs. Only one of the people who came in provided numbers of people affected—all the others were very emotional, with maybe guesstimates about the populations affected."

This tension between emotional appeals from the community and AP's need for empirical data to support decision-making continued to play a role. The Task Force came up with a prioritized list of groups needing services and with unmet needs, which was rejected by the Planning Council as lacking sufficient scientific support for the prioritization. The Task Force was given a second opportunity to establish priorities, but the result was a list of priorities reflecting the needs of only a few community agencies. This, too, was rejected, and it fell to AP staff to determine priorities.

The problem with the Task Force's recommendations had been the lack of a scientific basis for the priorities. AP staff based their work on epidemiological data, previous plans, and prior work identifying services and gaps in services. This was supplemented by comments and input from a review panel consisting of Planning Council members, community members who had been involved in previous strategic planning efforts, and community members who were actively involved in research or service provision in the areas being examined.

This iterative process was used to identify target populations as well as objectives and priorities. The Plan submitted in October 1994 identifies target populations, objectives, and priorities; the proposal outlined the process through which the CPG would expand upon this, including a more thorough needs assessment. As an AP staff member put it, "We didn't really intend for the Plan to be a needs assessment—more a comprehensive look at what's going on, with a thorough needs assessment down the road."

This effectively illustrates one of the difficulties faced in community planning for HIV prevention: "balancing science and passion." In general, AP staff and public health professionals are accustomed to the need to provide scientific support for their decisions and recommendations. Community members, however, may be more swayed by emotional appeals or highly charged presentations. The challenge is to capture the passion and commitment of the community while still maintaining the necessary scientific foundation.

Groups Identified

Identified groups were taken from two sources—the Los Angeles County HIV Strategic Plan and the Epidemiology Report (see Table 15). The CPG is using the groups as outlined in the Strategic Plan as the foundation for the groups that will have to be targeted for prevention efforts. The LA CPG has yet to go through the process of finalizing target groups and of prioritizing their needs. Members will be using the epidemiologic data, the needs assessment data, and including the public hearings and focus group data to finalize a list of target groups and then prioritize needs.

During the interview, the epidemiologists were asked their professional opinion as to which groups they thought were the most vulnerable to the spread of HIV. The epidemiology unit believes the two groups most vulnerable to HIV are (1) gay men of color, especially African Americans, but including all gay men of color; and (2) those injecting drug users who are not in treatment facilities.

Table 15
Comparison of Target Groups Named in Strategic Plan and in CDC Application

The target groups named in the Strategic Plan are (alphabetically)[a]:	Target groups named in CDC application are (alphabetically)[b]:
■ Adolescents	■ Adolescents
■ African Americans	■ Gays and Bisexuals
■ Asian and Pacific Islanders	■ Incarcerated and Recently Released Persons
■ Incarcerated Adults and Youth	■ Injection and Non-injection Drug Users
■ Injecting Drug Users and other substance abusers	■ People of Color-Persons of African Descent
■ The Homeless: Adults, adolescents of and Runaway Youth	■ People of Color-American Indians
■ Deaf and Hearing Impaired	■ People of Color-Asians and Pacific Islanders
■ Gay and Bisexual men	■ People of Color-Latinos
■ Gay Men of Color	■ The Homeless
■ Latinos and Latina	■ People with Tuberculosis
■ The Mentally Ill	■ The Mentally Ill
■ Native Americans	■ Sex Workers
■ Women	■ Transgenders
■ Transgenders	■ Immigrants and Undocumented Residents
	■ Women
	■ People with Special Needs

[a] AP LA DHS, LA County *Strategic Plan*, January 1994

[b] AP LA DHS, *CDC Application*, October 1994

3.3.4 Needs Assessment

The needs assessment activities in Los Angeles County are described by respondents as an effort designed to complement the epidemiology findings. The October 1994 application to CDC used the existing Strategic Plan as a basis for the needs assessment. The expectation was that activity would be conducted by the CPG in the period from October 1994 to July 1995. Because those efforts were ongoing at the time of the Battelle site visits in November 1994 and January 1995, they were frequently discussed by CPG members and AP staff.

Los Angeles County respondents express the goal of the needs assessment as identifying and defining HIV/AIDS prevention needs in the county. This effort is seen as complementary to the epidemiologic profile. The role of needs assessment is presented as identifying target populations and needs based on input from service providers and community members. As one respondent noted, "Epidemiology doesn't have all the answers. Never assume that a single source is going to tell the whole story. Never assume that you know all the target populations." One of the strengths of the approach is the use of multiple sources of information on community services and community needs. The activities being conducted include the following components:

- Identifying all community groups and service providers involved with HIV and AIDS prevention;
- Conducting telephone interviews with service providers;
- Sending a mail survey to service providers;
- Conducting 13 public hearings across Los Angeles County specifically for community input; and
- Conducting focus groups with community members.

These activities are designed to reach traditionally underserved and disenfranchised populations. CPG members and AP staff spoke of their willingness to perform outreach activities as needed to hear from all affected communities.

The needs assessment is expected to result in a comprehensive picture of both the breadth of services available in Los Angeles County and the unmet needs. This information can then be used to target prevention services as well as to evaluate the efficacy of those services in the future.

Prioritization of Needs

The CPG in Los Angeles has not gone through the process of prioritization of prevention needs because they felt they had not gotten all the input they required. Individuals interviewed acknowledged that the process must occur and that some sort of weighting based on need will be necessary. However, no one yet knows what, how, or which criteria will be used in the process of prioritization of prevention needs. The CPG has the responsibility of going through the prioritization process. While some members expect this to be a difficult and contentious process, they generally expressed confidence in the CPG's ability to maintain their commitment to the enterprise and accomplish this task.

The LA County HIV Strategic Plan approved by the Planning Council does make recommendations for prioritizing funds. The CPG is aware of these recommendations but does not know if they will be followed. Issues associated with prioritization raised during the site visit were mostly associated with doubts that the recommendations the CPG is making will carry any authority.

3.3.5 The Los Angeles County Prevention Plan

The HIV Prevention Plan was based in large part on the Los Angeles County HIV Strategic Plan for Fiscal Years 1993/1994 through 1995/1996. This document was developed by the health department with community input and presented to the Planning Council. Later, the CPG formed a subcommittee that took on the task of writing the HIV Prevention Plan.

Health department personnel and the CPG agreed that the October 3 Plan would be subject to change, depending on what the data from the different CPG processes (needs assessment, community-based interviews, public hearings, service provider interviews and survey data, focus groups) would show. Some CPG members were looking forward to developing and making recommendations about creative educational programs that would be useful in prevention. The CPG definitely felt a challenge lay ahead.

Some members exhibited skepticism that they really would be able to come up with anything better than the "status quo" in terms of prevention. A member said,

> "My fears are that people are doing what they've been doing for the last ten years. Prevention efforts haven't been effective and we're replicating that. The public health model is that if you give

> information to people, they'll change their behavior. As a therapist, I know this isn't true. People don't feel like they're allowed to talk about what they really do. We're assuming people have changed their behaviors because we told them to, and they don't tell us they haven't. In general, people are not willing to talk non-judgmentally about these issues."

The needs assessment and epidemiology sections were drafted by the appropriate health department experts. Drafts of the Plan were written and rewritten by the CPG. The Plan was presented to the full CPG at different points, beginning with a discussion of the existing Plan during the second CPG meeting. The item "Progress of the Plan" was on every meeting agenda until the due date of October 3, 1994. CPG members reviewed draft documents of the Plan and made suggestions and comments during the meetings. The subcommittee synthesized the comments and, with help from the health department, advisors, co-facilitators and other personnel, completed the document and turned in the HIV Prevention Plan to CDC by the due date.

3.4 Relationship of the Community Planning Process to the Community

Because of the size and diversity of Los Angeles County, a perception was exhibited consistently among interviewees that there is not one Los Angeles community but rather multiple communities, some of which overlap. CPG members were able to identify the communities they represented, in terms of geographic region, ethnic group, or personal or behavioral characteristics. However, no respondents could characterize or even conceptualize a single, unified Los Angeles County community.

The CPG made a variety of efforts to involve the community in the planning process. It was noted that "prevention people tend to be closer to the community" than those whose focus is care and treatment. Each CPG meeting has dedicated some time to public comment, but very few members of the public attend or comment. One CPG member suggested that this might be due to the mid-afternoon CPG meeting time, when most community members have work-related obligations.

In general, an AP staff member pointed out, "there has been very little interest from consumers, Planning Council members, or representatives from community-based organizations." The explanation offered for this was that these constituencies believe that no funding is associated with the work being done by the CPG and, therefore, see no benefit to be derived from participating

in the planning process. Yet, other AP staff point out that low attendance is not the same as lack of interest.

The activities being conducted by the CPG to update and expand the October 1994 submission include several mechanisms to involve the community through public hearings, outreach interviews, and focus groups. CPG members are eager to hear from the community, both from community-based agencies and institutions and individual residents of Los Angeles County.

Through presentations at CPG meetings and interactions with other participants, CPG members were expanding their understanding of the varied communities and needs in Los Angeles County. Most respondents were unsure what effect the community planning process would have in the community. One CPG member said, "Through the process I think we will come to a better sense of community as a whole, especially through focus groups and input from advisors. There will be a stronger sense of community."

3.4.1 Relationship with Other Planning Bodies

Earlier in this report, we discussed some of the other planning entities in Los Angeles County. The key county entities are the following:

- The HIV Health Services (Ryan White) Planning Council, which has the authority to allocate all AIDS monies.
- The HIV/AIDS Commission, which addresses issues of policy.
- The AIDS Regional Board, which includes representatives from over one hundred community-based organizations providing AIDS services. The AIDS Regional Board has an Education and Prevention Task Force.

These county entities are presently undergoing a consolidation process. However, that process was not complete at the time of Battelle's interviews, so the following information reflects the perceptions and experiences of respondents through January 1995. In addition, there is a state Community Planning Working Group (CPWG), which is the state CPG.

3.4.2 Coordination with the Planning Council

The CPG is a select committee of the Planning Council. As such, it is not an autonomous entity but is chartered to make recommendations to the Planning Council. The Planning Council may accept or reject these recommendations, but may not change them. Because of the broad power and established nature of the Planning Council, it looms large on the landscape of the CPG. As noted elsewhere in this report, the CPG adopted various structures, processes, and strategies to distinguish itself from the way the Planning Council had done things.

The expertise of the Planning Council's membership lies in the realm of care and treatment. Several respondents noted that Planning Council members do not understand or value prevention efforts. Further, most Planning Council members hold relatively high-level positions within their organizations. As such, they are more familiar with policy issues than with those issues faced by service providers. This is a source of frustration for some CPG members.

3.4.3 Coordination with Other Los Angeles County Bodies

The issue of coordination in Los Angeles County was further complicated in January 1995 when the county Board of Supervisors voted to combine the Planning Council with the AIDS Commission, resulting in a single body authorized to address both policy issues and funding allocation. It is not yet clear what effect this will have on the CPG.

The AIDS Regional Board of Education and Prevention Task Force is comprised of representatives of community-based organizations. They tend to focus on specific target groups (e.g., gay men of color). Prior to the inception of the CPG, AP tended to draw upon the Task Force for representation of community prevention needs. At this time, the Task Force is another source of community input.

3.4.4 Coordination with the State CPWG

Two members of the state Community Planning Working Group (CPWG) act as advisors to the Los Angeles CPG. However, the two bodies appear to operate independently of one another. There is greater coordination between the state CPWG and AP. AP staff attend CPWG meetings and

have contributed to the state plan; representatives from AP meet regularly with representatives from the state and San Francisco to coordinate activities.

The AP staff members working to coordinate with the state effort were most familiar with the CPWG's activities. While some local CPG members were aware of the state effort and had read and responded to the CPWG's draft plan, others were unfamiliar with the state's activities in prevention planning.

3.5 Barriers and Solutions

Participants were asked to discuss the major barriers they had encountered during the community planning process, as well as to share any solutions that were developed to overcome difficulties. It is interesting to note that some issues that emerge as barriers are also considered strengths of the process.

3.5.1 Effects of the Timeline

Generally, interviewees felt that the major pressure encountered in the community planning process was the timeline for submission of the application to CDC. Because the first meeting of the CPG was held in July, the group was under a great deal of pressure to complete the application by the October deadline. The CPG was fortunate in that Los Angeles County had been doing strategic planning for several years and, in the words of one respondent, they were able to "piggy-back onto the existing plan."

Respondents noted that time pressures dictated the use of the target populations in the existing Strategic Plan as a starting point. While they would have preferred to begin the determination of target populations with no pre-existing assumptions, such an activity would have taken an enormous amount of time (12 to 18 months have been allocated for the current needs assessment activities). Thus, completing the needs assessment in only three weeks was cited as a major hurdle.

An AP staff member indicates that the timeline also affected group dynamics and leadership. "It created problems to have to meet only once and elect the co-chairs. The co-chairs had to be chosen right away, but it would have been better to allow the group to function and get to know each other before selecting the co-chairs."

It should be noted, however, that some respondents viewed the time pressures in a more positive light. Having the deadline helped the group to focus on the immediate task at hand. The CPG was willing to meet twice a month until the Plan and Application were submitted. Subcommittees met more frequently, and this hard work and dedication during that time was committed on by several respondents.

3.5.2 Purpose of the CPG

Respondents from AP and the CPG expressed the concern that the CPG was having difficulties with its purpose and identity. These identity issues seem to fall into three areas:

- What is the purpose of the CPG?
- What are the respective roles of AP and the CPG in achieving that purpose?
- Should the focus be on outcomes or the process of participation?

The issue of purpose is complicated by the relationship of the CPG with the Planning Council. While AP staff were clear that the purpose of the CPG was "to update the strategic plan based on community needs and epidemiological changes," group members expressed greater uncertainty. A series of questions have been raised by CPG members:

- Is the CPG a decision-making body?
- Is the purpose to generate a plan?
- Is the purpose to allocate prevention funding?
- What will the Planning Council do with the CPG's findings?

As long as these issues remain unresolved, some uncertainty regarding purpose will probably persist.

The issue of ownership of the planning process is one that was raised by both CPG members and AP staff. There is a strong desire on everyone's part that CPG take ownership of the process from AP; however, AP staff are still more familiar with the expectations of community planning than the CPG. AP staff pointed out that many CPG members were new to the policy and planning arena

and that some uncertainty is to be expected as part of the process of growing together as a working group. A CPG member seemed to concur noting that:

> "these kinds of committees need a growing period ... so we can come to the point of all coming together on an issue, instead of by special interests. They need to allow us to cross-pollinate and hope that we become larger than individuals who represent special interests. That's what the purpose of these committees should be."

The third aspect of the confusion over purpose might best be described as a difference between a process orientation and an outcome orientation. To some CPG members and AP staff, the purpose of the CPG is to move through the agenda, accomplish specific tasks, and get things done. Other CPG members, however, view the purpose as being more about process and participation than outcomes. The more process-oriented CPG members say things like:

> "We're not a decision-making body, and a lot comes down to that. Why can't we all sit around a room and talk about it? You don't need formal motions and nameplates and a parliamentarian to do that."

> "Our work is taking the body [CPG] to the community, or bringing the community to the CPG body. The strength of the CPG is the diversity of the group, so if we all participate and get people to participate, it should work."

To some CPG members, their purpose is to generate a plan; to others, it is to determine priorities for funding prevention services; and still others believe their purpose is to enhance community involvement in the planning process. It must be noted that these purposes do not inherently conflict.

3.5.3 Conflict Resolution

Respondents discussed a variety of group process methods for managing discussions and resolving conflicts. The formal methods for guiding group discussions are found in parliamentary procedure and Roberts Rules of Order. The CPG co-chairs selected one of the more active participants in discussions for parliamentarian and charged this person with maintaining a list of CPG members who wished to participate in discussions. Some difference of opinion arose about when the parliamentary procedures were established for the CPG; some respondents indicated that it was from

the first meeting, while others believed that it dated from the third or fourth meeting. Several respondents did not recall voting to establish these procedures.

CPG members' reactions to parliamentary procedures varied. Some recognized that such procedures were useful to bring structure to discussion and to facilitate moving through the agenda. Others recognized their necessity under California's Brown Act, which establishes open meeting and documentation requirements. However, drawbacks were noted by numerous respondents. As one group member said, "I know it's the law, but I don't think it's conducive to participation." Not all CPG members were equally familiar with the intricacies of parliamentary procedure, and such formality tended to inhibit participation in discussions. Both community co-chairs noted this drawback and agreed that the rules have been a source of frustration for the group. None of the respondents could suggest an alternative method for guiding discussion while meeting statutory requirements.

Respondents varied in their perspectives on how conflicts were resolved. Some respondents, including AP staff, reported that the CPG operated on a consensus model. Others pointed out that the voting rules dictated a majority rule, so that if consensus was not achieved, a vote was taken. This was the case in the meeting observed by Battelle staff in November 1994.

The degree of conflict perceived or experienced by CPG members varied. For the most part, CPG members are in agreement about the fundamental issue facing their committee: the need to improve the delivery of HIV prevention services. One respondent said, "Maybe because we all agree about HIV—we're the choir—we disagree about process things." Several respondents also discussed the process of resolving conflict:

> A co-chair reported that "we don't have a formal process for handling complaints or grievances—only within the context of group discussion."
>
> "Sometimes I feel like all we do is process—it feels like we're not doing anything."
>
> When asked how conflicts are resolved, another member replied, "Long, long comments and discussion."
>
> "Conflicts are not totally resolved. Most, if not all, are addressed, but I don't know that they are resolved. The same issues seem to be a continual problem [e.g., the issue of representation]. Meetings may be more about people being heard than about resolving issues." [A committee co-chair]

Above all, respondents spoke of the mutual trust and respect that CPG members demonstrate in shaping all discussions. However, both a co-chair and an AP staff member noted that the co-chairs need to take more of a leadership role to guide discussions through to resolution. It was noted that CPG members really listen to, challenge, and respond to each other; this mutual respect was seen as a strength of the process. It is not without its perceived down side, though. One CPG member noted that discussions at times seem "very politically correct." Another noted that "for the most part, the people in there don't yell and shout, and don't know how to be in your face about AIDS. For some of us, AIDS *is* in your face." While most participants appreciate the cordial and respectful tone of the interactions, for some members the passion that compels them to work in the area of HIV and AIDS was lacking from the CPG meetings.

Group Process Issues

Respondents raised a number of group process issues in discussions of barriers to progress. Some felt the group suffered from not having sufficient time in the beginning of the process to develop the group as an integrated team. Getting everyone to feel comfortable participating was also noted as a barrier to full inclusion. Several CPG members suggested that the formality of the meetings may inhibit some members from participating. However, it was noted that formal processes, such as Roberts Rules of Order, were necessary to moving through an agenda and getting things accomplished.

The passionate feelings, reactions, and commitments that revolve around AIDS and HIV are seen as both a strength and a difficulty. This passion provides the energy and drive that fuels the process but at the same time poses difficulties when it runs up against the need for a scientific foundation for decision-making.

3.5.4 Political Concerns

Political considerations were offered by several respondents as barriers to effective prevention planning. For example, AP's ability to fund distribution of bleach and condoms or needle exchange programs has been constrained by political restrictions. Similarly, politics affects the ability to hear from or reach incarcerated populations effectively: both state and county authorities may have jurisdiction, and there is a general unwillingness to acknowledge that sexual behavior and drug use do

occur among the incarcerated. An epidemiological expert noted that "the interstices between policy and data are what is critical—you have to do what you can to shape how the data are used for decision-making."

Relationship with Planning Council

The issue of the relationship between the CPG and the Planning Council was raised as a barrier but also as a strong point of the process. Some respondents cited difficulties in trying to accomplish prevention activities through a care-and-treatment-oriented body like the Planning Council. They expressed a "lack of understanding on the part of the Planning Council, related to their lack of understanding of prevention issues and the need for prevention." One CPG member said that "care people just don't understand prevention."

This perceived obstacle was addressed by advocating for more seats dedicated to prevention on the Planning Council and by getting the CPG co-chairs named as advisors to the Planning Council. The more visible the prevention presence, the more likely that prevention needs would be recognized.

An AP staff member spoke in favor of the relationship with the Planning Council. The response to a question about what had worked especially well was that integration with the Council "places the CPG appropriately as part of the continuum. Prevention issues are not separate from care and treatment issues. Our plans have stressed the continuum of care, with primary and secondary prevention as linked."

Representation Issues

As mentioned previously, the issue of whether the CPG was sufficiently representative loomed large in the group. It was frequently raised at CPG meetings and several respondents noted it as a barrier, insofar as continuing discussions of the issue took up time that could have been spent on other topics. Adding advisors to the CPG emerged as one solution to this and many respondents spoke of the advisors' role as one of the strengths of the process. In addition, allowing the group the time to work through the issue and come to terms with their own expertise was also cited as a useful mechanism. It should be noted that respondents did not agree about whether this issue had been fully resolved: some saw the group as having moved past it, while representation was clearly still an issue for others.

Ownership

The question of ownership seemed to be an ongoing issue between the CPG and AP. AP staff often took a leadership role in defining or clarifying expectations for the CPG, though they remained aware of the perils of doing so. AP took a strong lead in the early stages of the community planning process and over time has ceded more responsibility to the CPG. Both AP staff and CPG members occasionally expressed frustration with this. They seem to be caught in a double bind: some CPG members have come to expect AP staff to play an active role and look to AP for guidance precisely when AP is hoping to turn responsibility back to the CPG.

While AP is the recipient of CDC funds for community planning, initiated the process, and continues to play an active role, both AP and CPG representatives spoke of the essential need for the CPG to take ownership of the process. This raises several difficult questions:

- Can the CPG "own" a process that is run by AP?
- Is it appropriate for AP to cede responsibility and ownership to the CPG, when it is AP that will be held accountable to CDC for the effectiveness of the community planning process?
- Should community planning monies be granted to communities rather than to local health departments?

Answering these questions presents a challenge to both AP and the community members themselves.

3.5.5 Strengths of the Process

When asked what aspects of the process had worked especially well, respondents offered a number of features. Some were unique to the process as it unfolded in Los Angeles, while others provide useful lessons for other communities.

The most common response to this question had to do with the particular group of individuals who made up the CPG. They were saluted for their dedication, their mutual trust and respect, their diversity, and their ability to wear more than one hat. One respondent spoke of the value of "including people in the process who didn't have a voice before;" another referred to the "good mix of professionals and community-based activism." In brief, the CPG was referred to as "an outstanding group of people."

Other successful aspects of the process had more to do with the structure and implementation of the planning process. These included:

- Keeping the CPG a manageable size,
- The use of advisors to supplement the expertise on the CPG, and
- The use of subcommittees to accomplish specific tasks.

Finally, an AP staff member noted that "the success we've had lies in having a reasonably good relationship with the community."

Advice and Recommendations

Participants were asked what advice or recommendations they would offer to enhance the effectiveness of the community planning process. This advice took several forms: advice to other CPGs, advice to CDC, and advice to those who implement the CPG process.

The single issue raised by the largest number of interviewees was the need for a retreat or some other kind of team-building activity. This was offered as advice to other CPGs as well as to CDC, in the form of a recommendation that resources be provided for such an activity. An AP staff member suggested that this would provide "the opportunity to go through all the stuff about the purpose and the process using an outside source as an honest broker. Someone needs to help the group understand the planning process and what the CPG can do to make it happen." This was echoed by a co-chair, who pointed out that a retreat "would have facilitated group interaction and provided a venue for knowing group members and understanding their strengths and weaknesses."

In a similar vein, two respondents suggested allowing the group time to get established and acquainted before selecting the co-chairs. This would allow the opportunity for members to demonstrate their expertise and leadership skills. However, it would also leave the health department staff in charge of the process a little longer, and respondents were wary of allowing this to occur.

Indeed, building CPG ownership of the process and the Plan was also offered by several respondents as a key recommendation. One suggestion from an AP staffer was to encourage the CPG "to figure out *how* to accomplish the things that AP decides need to be done." This would build CPG involvement in and ownership of the process.

Two respondents also stressed the need for a great deal of community input throughout the planning process. This can be accomplished through a number of means in addition to membership on the CPG; for example, public hearings, focus groups, and other outreach activities.

One respondent offered a series of recommendations to be implemented with additional resources:

- A media consultant, to enable the CPG to take full advantage of public discourse.
- Additional behavioral research, which was seen as "really necessary to design interventions."
- A dedicated epidemiology person to ensure that the community planning process is built on a scientific foundation.

A CPG member offered advice to CDC, "You're not always going to have full representation of a single group. CDC guidelines should have been more clear about what the selection process should be, what the role of advisors is, and so on." In addition, it is essential to get the perspective of people working in the field on the guidelines.

Subcommittees were recommended as a way of getting specific tasks done. One CPG member urged that group members be given clear assignments and then be held accountable for their contributions.

Several practical issues were mentioned as well. CPG members remarked that it would be nice to offer refreshments at meetings. In addition, some CPG members felt strongly that they should not be identified in terms of which agency they worked for, since they were supposed to represent multiple communities.

The need for good behavioral and attitudinal data was mentioned by several respondents as essential to the ability to design interventions effectively to halt the transmission of HIV.

Finally, two respondents suggested that the community planning process may have evolved "backwards." Rather than provide community planning funds to the local health department with the stipulation that they involve the community, these respondents suggested that a more community-based approach would be to fund the community with the stipulation that they involve the local health department.

3.6 Summary—Los Angeles County

HIV prevention community planning in Los Angeles County has been fueled by dedication and commitment on the part of the community, CPG members, and AP staff. Through their efforts and actions, a number of challenges inherent in the community planning process have been illuminated. Many of these challenges simultaneously provide opportunities for observing the strengths of community planning in Los Angeles.

Los Angeles County is very large and diverse. It has a history of HIV/AIDS prevention planning involving multiple entities (notably the Ryan White Planning Council, the AIDS Commission, and the AIDS Regional Board Task Forces). The CPG is a select committee of the Planning Council. Thus, the present consolidation of the major HIV/AIDS planning bodies affects the CPG. While some respondents expressed a degree of reservation over their status, generally the relationship between the CPG and the Planning Council was seen in a favorable light.

3.6.1 Challenges

With this background in mind, we will focus on the following challenges (some of which contain their own solutions) that emerge from the case study of Community Planning in LA County:

- Achieving representativeness on the CPG.
- Perceptions of members regarding data and purpose.
- The effect of the timeline for submitting the Plan.
- The context of planning within a large, diverse setting with multiple bodies.

An early decision was made to limit the size of the CPG and Advisors were used to supplement the constituencies not fully represented on the CPG. As we mentioned in the summary to Chapter 2, we consider this to be a reasonable solution to the tension between having a group small enough to work together effectively and being sure that all affected populations are represented. The attendance of the advisors varied markedly. Perhaps it would be useful to follow up on these advisors to see how their knowledge and expertise can be maximally utilized.

Both case studies showed areas where member respondents were confused about issues for which they received written guidance. In Los Angeles, as in Washington, members were not sure about the purpose of community planning even though they were able to give the researchers a statement of purpose often very close to that cited in CDC documents. Another area of misperception was in the type of behavioral data available for Los Angeles. Respondents said they were upset that the RAND data focused on affluent gay white men, but, in fact, one of the surveys had oversampled minorities. In another example, a respondent criticized CDC for lack of attention to "people in the field" when it developed its guidelines. However, CDC did have advisors from the field.

Misperceptions may be due to "information overload" as cited in Chapter 2. In addition, the local health department and CDC may not be getting all necessary information out to the jurisdictions effectively, such that members do not fully understand the assumptions underlying community planning. Even so, there were broad areas of agreement among respondents with regard to ways of improving the process (a process of which they were generally proud). Suggestions for improvement include more behavioral and attitudinal data and greater community input from the grassroots level. This is presently being accomplished through public hearings and focus groups.

The timeline, while challenging, did not appear to be as problematic for the Los Angeles CPG as it was in Washington. This statement does not minimize the amount of time members spent at meetings and the dissatisfactions voiced over the use of "old" data for the epidemiologic profile. The main difference between the two groups was the fact that in Los Angeles a great deal of relevant data collection had been done on a Strategic Plan completed only several months before the implementation of the CPG process. Therefore, it was decided to use needs assessment and other data from the Strategic Plan as a foundation for the October 3 HIV Community Prevention Plan and to supplement this information later.

Respondents expressed concern that the timeline prevented the development of group dynamics that would allow everyone to get to know each other well. For example, one person would have liked more time to get to know the members before electing co-chairs. On the other hand, the timeline did create a strong focus that may have led to group cohesion.

The existence of multiple HIV/AIDS planning bodies in Los Angeles added some unique political concerns to the context within which the Los Angeles CPG has been functioning. While some respondents would have preferred to be a separate entity from the Planning Council, others felt that the CPG's presence as a select committee actually strengthens prevention, an area that has received short shrift in the past.

3.6.2 Strengths

As the discussion of challenges demonstrates, each of the areas highlighted also had a beneficial aspect. Even the discussion of dissonance in perception regarding purpose and CDC guidance demonstrates a high level of concern by members that community planning be as open and effective as possible.

The strengths that emerge from this case study are legion. We would like to summarize them under two topic areas. These are (1) advocating for prevention and (2) the development of the CPG.

HIV/AIDS planning has a long history in Los Angeles. Yet, many of the planning bodies were previously concerned with treatment issues; the focus of some of the entities appears confusing. The CPG provides a single focus for HIV prevention community planning. While a small group within itself, it is presently working to include a broader community viewpoint.

Advocacy for planning could not be effective if the CPG was not an effective body. This includes the leadership of the CPG, and the willingness of the leadership to begin to pull back and allow for greater ownership of the group by the community. It was laudable that a decision was made to bring new people into the process from the beginning, a decision that required development of the group at a time when they were under a great deal of pressure to produce a product, the Community Plan and Application. This decision showed a dedication to making community planning a true community process.

In summary, the Los Angeles jurisdiction, like Washington DC, was able to produce their Plan by the October 3 deadline. The health department and the community worked together to complete this task. At the same time, with increasing community input, members are seeking to improve upon the Plan they submitted. This in turn can only strengthen the process of community planning in the long term.

Chapter 4.0

Conclusions

4.0 Conclusions

Our primary purpose has been to present information that details a new effort, community planning for HIV prevention. The participants in this process are pioneers. As such, the experiences of Washington DC and of Los Angeles County may provide valuable lessons for others who enter into community planning in the future. These lessons may also improve the ongoing and continually evolving planning process in presently funded jurisdictions.

Structural differences exist between the two CPGs that form the subset of this study, such as the Los Angeles CPG's unique relationship with the Ryan White Planning Council as a select committee. Even with these differences, conclusions can be drawn about the process of community planning in the two jurisdications.

4.1 Inclusiveness and Representation

In both Washington DC and Los Angeles County, members of the planning groups believed they were provided with a good opportunity for building networks and sharing ideas. These networks were based upon selection of persons with varied backgrounds in HIV and AIDS prevention and education. Members welcomed the opportunity to meet others who worked with HIV/AIDS, especially people with whom they would not normally come into contact. They were especially pleased with the effort to select members as individuals and not as employees of an AIDS-related organization.

The mechanism for ensuring broad-based representativeness varied somewhat in each jurisdiction. Washington DC spread a wide net, accepting 40 members,[1] but when it came to doing the actual work of the CPG, a core group of about 20 developed. Los Angeles purposely limited its size to 23 members and called in advisors for specific areas.

The nomination process encountered difficulties in Los Angeles County due to the need to conduct two mailings, resulting in some persons receiving duplicate nomination forms. Both groups expressed some concern that certain target populations, such as subgroups from among Latinos, were

[1] Two additional slots are being held for youth members who have not yet been selected.

not adequately represented in the final committee configurations. While each jurisdiction could probably benefit from broader advertising for nominations in the future, respondents generally gave high marks to the nomination and selection processes.

4.2 Purpose of Community Planning

Participants in both case studies cited what they perceived to be a lack of understanding concerning the purpose of community planning. Yet, when probed, they generally gave appropriate responses in line with CDC guidance, such as (1) produce a product, the Comprehensive Community Plan; (2) enhance community involvement in the planning process; (3) act as an advisory body to the local health department; and (4) determine priorities for funding prevention services. In addition, some members also felt that the CPG should provide monitoring and oversight of HIV prevention activities.

Some committee members were also uncertain as to exactly what they were expected to produce. For example, some members were satisfied with a needs assessment based largely on the one done for the Strategic Plan (LA), or with submitting an abbreviated needs assessment using limited new data from focus groups, surveys, and informant interviews (DC), but with the understanding that gaps would be filled in after the October 3 submission deadline. Other respondents were quite concerned about using older or incomplete data and wished to conduct the type of community needs assessment that generally takes six months to a full year to complete. We believe that greater direction from CDC itself would be helpful in clarifying how a needs assessment should be conducted and how it will be used.

4.3 Community Involvement

Members of planning groups in the District of Columbia and in Los Angeles expressed concern that the full community was not sufficiently represented, despite the CPGs' concerted efforts to be representative and inclusive. Considerable discussion took place, especially in Los Angeles, about what constituted the community and whether such a small group could adequately represent all constituencies.

Washington DC had initially planned to implement a two-tiered structure during the early phases of community planning. Although this plan was put on hold, it is being revisited at this time and will involve the establishment of four grassroots prevention groups designed to extend the reach of the CPG into the community as a whole. We believe this is an excellent idea that deserves the support and guidance necessary to implement it.

CDC has purposely defined "community" in an open and non-perscriptive manner, recognizing that many groups are affected by HIV and need to be brought into the planning process. However, such a definition poses a great challenge to the lead agencies required to bring in all individuals at an equal level. Los Angeles purposely sought representatives not at the top of their organizational structures. Due to the fact that Washington's group is very large, the membership is also very diverse. Even so, most members are well educated and familiar with HIV prevention issues. However, if persons from more diverse populations (e.g., varied socioeconomic, cultural, and ethnic groups; youth; inmates) are to be included in planning, assistance will be needed to improve parity for those from widely divergent backgrounds.

4.4 Organizational Structure and Support

While both CPGs were careful to delineate a clear organizational structure, these efforts were strained during the real-life pressure of producing a Comprehensive Plan. Washington DC was more comfortable with the use of a parliamentarian and Robert's Rules of Order than was Los Angeles. Los Angeles had more support from the county government for group facilitation; in fact, Washington DC had selected a coordinator for the CPG, but District personnel policies prevented hiring that person until after the October 3 deadline.

For Washington, it may be important to revisit the notion of an Executive Committee able to address the numerous advocacy issues that arise without using the precious meeting time needed to conduct the work of planning. The need for an Executive Committee was less acute in Los Angeles, possibly because it has a smaller CPG. It is possible that the DC CPG is too large and may benefit from paring down its membership and then using advisors for specific tasks, as has been done in Los Angeles.

The subcommittee structure for carrying out particular tasks was certainly necessary. It is interesting to note that the most highly structured and task-oriented subcommittee (Washington DC's

Program Initiatives and Strategies Subcommittee) had the most faith in the product it developed (prioritization of populations and interventions). We believe that further technical assistance may be needed to maximize the subcommittee structure within the kinds of time constraints that the CPGs face.

The Los Angeles CPG is a select committee of the Ryan White Planning Council. Washington DC maintains a fully independent CPG, but two Ryan White members sit on the CPG as ex-officio members. Communication between the two groups appears to be good.

4.5 Orientation and Training

Planning Group members were fairly positive about the orientation process. Participants were given huge amounts of material, and a respondent suggested that it would have been more useful to receive shorter documents in bulleted form. There was a consensus in both CPGs that all members should attend orientation, and that more time should be spent on team building. In Los Angeles, workshops were held at meetings. Further training both in technical issues, such as definitions in public health and epidemiology, and in process issues has been implemented in Washington in 1995. Co-chairs were pleased with meetings at CDC that brought their peers together from jurisdictions and provided a forum for information exchange.

4.6 Access to Current Data—Epidemiologic Profile and Needs Assessment

Access to up-to-date information on HIV/AIDS prevalence was a primary concern in both jurisdictions. The inability to obtain current information readily was exacerbated by the October 3 deadline. In Los Angeles, the CPG seemed to accept the fact that they would be unable to use the most current data and that they might miss some key target populations. In Washington DC, a great deal of time was spent initially trying to obtain newer information; nevertheless, respondents expressed disappointment with the final data used for the Plan. Both jurisdictions are now attempting to fill in gaps that could not be addressed one year ago.

4.7 Time Constraints

One of the most problematic issues was lack of time. Time constraints clearly impaired the CPGs' ability to collect current epidemiologic data and conduct a thorough needs assessment, as discussed above. It limited their ability to contact all appropriate local agencies, to consult with experts whom members perceived to have critical pieces of information, and to carry out focus groups at the grassroots level.

CPG members in both DC and LA cited lack of time as the primary factor preventing them from coming up with innovative prevention measures. However, the stress was less acute in Los Angeles probably due to the data collection undertaken for the Strategic Plan in the months prior to the initiation of the CPG. This Strategic Plan provided a foundation for the October 3 Comprehensive Plan. Some respondents were not happy with the recommendations they put into their prevention plans. While it is laudable that participants wanted to do more, it would help in the overall effort of team building if members could step back and congratulate themselves on what they were able to accomplish within such a short timeframe.

While some respondents spoke about the cohesion that developed from working together under so much pressure, the timeframe was also a major stressor. Conflicts were generally dealt with through parliamentary procedures, or by "talking things through as adults." However, some interviewees felt that discussion was rushed and not everyone was heard. This also meant undue frustration for leaders who sincerely wished to be inclusive. Difficult issues, such as the rating of target populations, were not aired to everyone's satisfaction.

We would advocate that CDC provide the CPGs with further training and technical assistance so that the Planning Groups can prioritize the elements of the Plan and carry them out within a reasonable timeframe. For example, an urban jurisdiction requires about one year for a thorough needs assessment. Since this is not possible within the present funding cycle, one solution may be to help the city decide which aspects of the needs assessment must be accomplished each year, and which will be the focus for subsequent years in a five-year cycle. Technical assistance should also extend to group facilitation under time pressure. Even so, we felt that active members were extremely dedicated, and that it was difficult for them to do less than they would have liked to do in a more perfect scenario.

4.8 Summary

The purpose of the case studies of the HIV prevention community planning process in these two urban jurisdictions has been to allow participants in these cities, participants in other CPGs, and CDC to learn about the issues that emerged during the first year of planning and the ways that the two groups have dealt with them. As descriptive case studies, their goal is to aid in understanding.

We realize that, unfortunately, local structural and fiscal problems exist that affect optimal community planning and are outside the purview of CDC. We also realize that we are writing about the experiences of two urban grantees out of a total of 65 grantees; whereas only seven[1] of these 65 are cities. These experiences and our interpretations may not be generalizable. Even so, they may offer possibilities for assisting new jurisdictions who may find a number of the same issues emerging as they embark on HIV prevention community planning.

Issues where the greatest similarities and differences emerged have been summarized above. In cases where the data lent themselves to suggestions for assistance, we have included those as well. We see the following areas as highest priority needs for assistance:

- Prioritizing the elements to be completed within the time commitment that is fixed by the funding cycle.
- Assisting the CPG members to verbalize the purpose of the CPG and the degree to which monitoring and advocacy are in line with that purpose.
- Providing training in both technical and process issues.
- Providing further support and guidance to enhance grassroots participation in community planning.

Despite the above suggestions for assisting the community planning process in these two jurisdictions, it is abundantly clear that the CPGs already possess considerable strengths. Prevention community planning has been fueled by the dedication of participants in both jurisdictions. The CPGs were able to carry out their goal of submitting a Plan by the October 1994 deadline through the commitment of their members, the local health departments, and CDC. In order to complete the Plan

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[1] Six cities are funded through the CDC *HIV Community Planning* Cooperative Agreement. The cities are Los Angeles, San Francisco, Houston, Chicago, New York, and Philadelphia. Washington DC was funded as one of the nine territories, although it is a wholly urban entity.

on time, each group demonstrated the ability to achieve consensus even under challenging circumstances. Without doubt, the membership of each group was highly committed and possessed many types of expertise. This fact reflects back to the effective strategies local health department grantees used for selecting the members through an open nomination process and then for implementing each group. Finally, the accomplishments of these groups would not have been possible without strong commitment on the part of CDC, the health departments, and the CPGs to act as partners in the community planning process.

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Program Initiatives and Strategies Subcommittee) had the most faith in the product it developed (prioritization of populations and interventions). We believe that further technical assistance may be needed to maximize the subcommittee structure within the kinds of time constraints that the CPGs face.

The Los Angeles CPG is a select committee of the Ryan White Planning Council. Washington DC maintains a fully independent CPG, but two Ryan White members sit on the CPG as ex-officio members. Communication between the two groups appears to be good.

4.5 Orientation and Training

Planning Group members were fairly positive about the orientation process. Participants were given huge amounts of material, and a respondent suggested that it would have been more useful to receive shorter documents in bulleted form. There was a consensus in both CPGs that all members should attend orientation, and that more time should be spent on team building. In Los Angeles, workshops were held at meetings. Further training both in technical issues, such as definitions in public health and epidemiology, and in process issues has been implemented in Washington in 1995. Co-chairs were pleased with meetings at CDC that brought their peers together from jurisdictions and provided a forum for information exchange.

4.6 Access to Current Data—Epidemiologic Profile and Needs Assessment

Access to up-to-date information on HIV/AIDS prevalence was a primary concern in both jurisdictions. The inability to obtain current information readily was exacerbated by the October 3 deadline. In Los Angeles, the CPG seemed to accept the fact that they would be unable to use the most current data and that they might miss some key target populations. In Washington DC, a great deal of time was spent initially trying to obtain newer information; nevertheless, respondents expressed disappointment with the final data used for the Plan. Both jurisdictions are now attempting to fill in gaps that could not be addressed one year ago.

4.7 Time Constraints

One of the most problematic issues was lack of time. Time constraints clearly impaired the CPGs' ability to collect current epidemiologic data and conduct a thorough needs assessment, as discussed above. It limited their ability to contact all appropriate local agencies, to consult with experts whom members perceived to have critical pieces of information, and to carry out focus groups at the grassroots level.

CPG members in both DC and LA cited lack of time as the primary factor preventing them from coming up with innovative prevention measures. However, the stress was less acute in Los Angeles probably due to the data collection undertaken for the Strategic Plan in the months prior to the initiation of the CPG. This Strategic Plan provided a foundation for the October 3 Comprehensive Plan. Some respondents were not happy with the recommendations they put into their prevention plans. While it is laudable that participants wanted to do more, it would help in the overall effort of team building if members could step back and congratulate themselves on what they were able to accomplish within such a short timeframe.

While some respondents spoke about the cohesion that developed from working together under so much pressure, the timeframe was also a major stressor. Conflicts were generally dealt with through parliamentary procedures, or by "talking things through as adults." However, some interviewees felt that discussion was rushed and not everyone was heard. This also meant undue frustration for leaders who sincerely wished to be inclusive. Difficult issues, such as the rating of target populations, were not aired to everyone's satisfaction.

We would advocate that CDC provide the CPGs with further training and technical assistance so that the Planning Groups can prioritize the elements of the Plan and carry them out within a reasonable timeframe. For example, an urban jurisdiction requires about one year for a thorough needs assessment. Since this is not possible within the present funding cycle, one solution may be to help the city decide which aspects of the needs assessment must be accomplished each year, and which will be the focus for subsequent years in a five-year cycle. Technical assistance should also extend to group facilitation under time pressure. Even so, we felt that active members were extremely dedicated, and that it was difficult for them to do less than they would have liked to do in a more perfect scenario.

4.8 Summary

The purpose of the case studies of the HIV prevention community planning process in these two urban jurisdictions has been to allow participants in these cities, participants in other CPGs, and CDC to learn about the issues that emerged during the first year of planning and the ways that the two groups have dealt with them. As descriptive case studies, their goal is to aid in understanding.

We realize that, unfortunately, local structural and fiscal problems exist that affect optimal community planning and are outside the purview of CDC. We also realize that we are writing about the experiences of two urban grantees out of a total of 65 grantees; whereas only seven[1] of these 65 are cities. These experiences and our interpretations may not be generalizable. Even so, they may offer possibilities for assisting new jurisdictions who may find a number of the same issues emerging as they embark on HIV prevention community planning.

Issues where the greatest similarities and differences emerged have been summarized above. In cases where the data lent themselves to suggestions for assistance, we have included those as well. We see the following areas as highest priority needs for assistance:

- Prioritizing the elements to be completed within the time commitment that is fixed by the funding cycle.
- Assisting the CPG members to verbalize the purpose of the CPG and the degree to which monitoring and advocacy are in line with that purpose.
- Providing training in both technical and process issues.
- Providing further support and guidance to enhance grassroots participation in community planning.

Despite the above suggestions for assisting the community planning process in these two jurisdictions, it is abundantly clear that the CPGs already possess considerable strengths. Prevention community planning has been fueled by the dedication of participants in both jurisdictions. The CPGs were able to carry out their goal of submitting a Plan by the October 1994 deadline through the commitment of their members, the local health departments, and CDC. In order to complete the Plan

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[1] Six cities are funded through the CDC *HIV Community Planning* Cooperative Agreement. The cities are Los Angeles, San Francisco, Houston, Chicago, New York, and Philadelphia. Washington DC was funded as one of the nine territories, although it is a wholly urban entity.

on time, each group demonstrated the ability to achieve consensus even under challenging circumstances. Without doubt, the membership of each group was highly committed and possessed many types of expertise. This fact reflects back to the effective strategies local health department grantees used for selecting the members through an open nomination process and then for implementing each group. Finally, the accomplishments of these groups would not have been possible without strong commitment on the part of CDC, the health departments, and the CPGs to act as partners in the community planning process.

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Appendix A

Appendix A
Study Questionnaires and Observation Guide[1]

This appendix consists of the following items:

- Individual face-to-face questionnaire for the Co-Chairs and for the Health Department Contacts
- Individual face-to-face questionnaire for the members of the Community Planning Group
- Individual telephone questionnaire for the members of the Community Planning Group
- Group interview guide for members of the Community Planning Group
- Individual telephone questionnaire for the community members who do not sit on the Community Planning Group
- A meeting observation guide

[1] The following documents were based in large part upon the questionnaires designed by the US Conference of Mayors (USCM). They were adapted for use with urban CPGs only, and were modified according to information which USCM and CDC shared with us as they conducted case studies in the months prior to the Battelle project.

HIV Prevention Community Planning
MAIN HEALTH DEPARTMENT CONTACT
COMMUNITY PLANNING GROUP (CPG) CO-CHAIRS

As we discussed over the telephone, the purpose of this interview is to learn about the way in which HIV community planning is implemented by city-wide HIV prevention community planning groups (CPGs). Your community is unique and we would like to learn as much as we can, but realize that our time is limited. The information we collect from you as well as from CPG members and other members of the community will be analyzed by myself and a few colleagues at Battelle. We will then send you a draft report. The draft report will not attribute any quotations or comments to particular individuals. Once you return it to us with comments and suggestions, we will revise the report to present it to the CPG as a whole. Finally, we will compile this case study with another city-wide case study and send the two case studies as a report to CDC. While each city will be identified in that report, again, no specific comments or quotations will be attributed to particular individuals.

Do you have any questions before we start?

****

Name of Interviewer: _____

Date: _____

Location: _____

****

Name of Interviewee: _____

Professional Affiliation:_____ Title:_____

Role in the community planning (CP) process:

[ ] AIDS Director
[ ] Representative of local health department (LHD)

Describe: _____

_____

[ ] LHD Co-Chair
[ ] Community Co-Chair

Stages of the HIV Prevention CP process completed by this group? [*Check all that apply*]

[ ] Nominating CPG members
[ ] Compiling the epidemiologic profile
[ ] Conducting the needs assessment
[ ] Prioritizing needs
[ ] Determining interventions
[ ] Prioritizing interventions
[ ] Writing the prevention plan

 # CPG members in present group: _____
 # Co-Chairs for this group: _____

I. BACKGROUND

1. How did you become involved with the CPG?

2. What are your responsibilities as a Co-Chair? (as the HD representative?)

   *[**For Co-Chairs:** How were you chosen to be a co-Chair? How do you divide responsibilities with each other?]*

II. THE COMMUNITY PLANNING PROCESS

For HD contact only (For Co-chairs, skip to question 2):

1. Who decided on on the size and type of CPG to form? How was this decision made?

2. Tell me about the nomination process for members of the CPG?

   [***Probes:*** *How was information about the formation of the CPG disseminated? To whom was information about recruitment or nominations sent? Why were these individuals or agencies selected? Whom do they represent?*]

3. How were decisions made regarding which groups of people to target when forming the CPG?

   3.1 What is the group composition like now?

   [***Probes:*** *Are you satisfied with this composition? What were some of the barriers to inclusion? What advice would you give to other jurisdictions?*]

4. Is it necessary to provide practical assistance so members may participate in the group?
[*Examples:* *transportation, day care, financial support (see below for training)*]

[ ] Yes [ ] No

If yes,
4.1 What kinds of assistance is provided?

[*Probes:* *Who provides this assistance? How is the assistance provided? What prevents the group (or its designate) from providing this assistance?*]

5. Have you found a need for training in any aspect of community planning among CPG members?

[ ] Yes [ ] No

If yes,
5.1 What kind of training is needed? Has it been provided? By whom?

6. Who prepared the Epidemiologic Profile? How was this person selected/identified?

6.1 What sources were used for the epidemiologic profile?

7. What was the format for providing the epidemiologic information to members of the CPG?

[*Probes:* *Were CPG members provided written materials? Oral presentation? Looking back on it, would you say the data were sufficient or appropriate for members with differing professional backgrounds; i.e., were they able to get a good understanding of the contents?*]

8. What are your main target populations? How were the target populations identified?

[*Probe:* *To what degree was the epidemiologic profile part of that process?*]

9. How did your group go about conducting the Needs Assessment?

[*Probes:* *Were social and behavioral scientists involved?*]

10. Tell me about the process for setting priorities for meeting unmet needs.

[***Probes:*** *Did you use the Needs Assessment? How much did you use the epidemiologic profile? (For LA - did this vary by region?)]*

11. Tell me about the process for prioritizing interventions.

11.1 Were cost-effectiveness issues part of the decision-making process for prioritizing interventions?

[ ] Yes [ ] No

[***Probe (if yes):*** *Can you give me an example of how cost-effectiveness was incorporated into your prioritization process?*]

12. How have non-CPG members participated in development of the plan?

[***Probes:*** *Can you give me some example of ways that consumers participated who are not members of the CPG? Providers? Do you have any suggestions for changes in the future?*]

13. How did the October 3rd deadline for producing the HIV Prevention Community Plan affect the planning process? What would you have done differently if you had had more time?

14. What features of the process for developing the Community Plan have worked well?

[***Examples:*** *individuals, groups, politics, aspects of the process, characteristics of this jurisdiction*]

15. Please tell me what barriers your group encountered during the HIV prevention planning process?

[***Examples:*** *individuals, groups, politics, aspects of the process, characteristics of this jurisdiction*]

15.1 How was your CPG able to overcome barriers?

15.2 Which barriers were not overcome? Why not?

16. What would you change about the CP process?

[***Probe:*** *What would have made it easier for your group to accomplish its goals?*]

17. What specific activities and strategies for implementing the CP process worked well?

17.1 What would you have done differently in implementing the CP process?

18. What specific lessons did you learn about running the CPG?

19. Please describe your group's decision-making process?

19.1 How do you go about resolving conflict?

20. Can you tell me about your evaluation of the CP process?

[Probe: Who (individual or organization) is responsible for data collection for evaluation?]

20.1 How have the evaluation data been used?

[*Examples: to improve the CP process, bring more groups in, etc.*]

21. How have the resources you have available for HIV CP planning affected the planning process?

III. EXTERNAL RELATIONSHIPS (D.C. ONLY)

1. What other HIV or AIDS planning groups exist in the District? in the metropolitan area?

1.1 What is the relationship of your HIV Prevention CPG with those groups?

III.1 COUNTY/STATE RELATIONS (L.A. only)

1. How are differences in the nature of the AIDS epidemic and of HIV prevalence in LA county and the state reflected in their respective HIV prevention plans?

[*Probe:* *How are funding and intervention decisions affected? How do you feel about these decisions?*]

2. Please describe any coordination between the County HIV Prevention CPG and the State HIV Prevention CPG.

[*Probe:* *Is the coordination informal or is there a formal structure or body through which coordination takes place?*]

3. **Has the County CPG used any of the State CPG's planning materials in preparing its own plan? If so, which materials were shared and how were they adjusted to meet the county's needs?**

4. **Historically, has HIV planning been done separately from or in conjunction with state planning? How is it different now?**

5. **What would you say are the advantages or disadvantages for the county in coordinating HIV community planning with the state?**

IV. SUMMARY

1. **Overall, what effect do you think the HIV prevention CP process is having on existing programs?**

   [*Probe: Please be as specific as possible.*]

   1.1 **What effect do you think the process will have on future HIV prevention interventions?**

   [Probe: ***Do you think that the quality of these interventions will improve in the future? Can you give us specific examples of improvements or new interventions planned?]***

2. **What are some of the innovative aspects of your planning activities or of the prevention plan itself.**

3. **I'd like to know what you think members of the CPG mean when they talk about "community?" Do you think there is consensus in the way this term is used?**

4. **How do you think that the CP process has promoted or hindered the development of a sense of community for your jurisdiction?**

5. **What are some of the things that <u>you</u> have learned are important to members of the community?**

THANK YOU VERY MUCH

HIV PREVENTION COMMUNITY PLANNING
INTERVIEW FOR COMMUNITY PLANNING GROUP MEMBERS

My name is_____, and I am from the Battelle Memorial Institute. We have been asked by the Centers for Disease Control to learn more about the way in which Community Planning is working in two cities which have specific Community Planning Groups (CPGs) for HIV Prevention. We are not evaluating this CPG. Instead, we are compiling a short report of information that will be used to improve the process in the future.

When we finish speaking with people in your community, we will share a report on this information at a CPG meeting and invite suggestions for improving the report. At no time will we ever attribute a specific comment or quotation to anyone. Once we make final revisions to this report it will be sent to CDC. At that time too, no specific responses to questions or statements will be identified as coming from any particular participant in this study.

Do you have any questions before we begin?

****

Name of Interviewer: _____

Date: _____

Location: _____

****

Name of Interviewee: _____ **(for tracking only)**

Affiliation: _____ **Title:** _____

Stages of Community Planning (CP) completed by this group: [*Check all that apply*]

- [ ] Nominating CPG members
- [ ] Compiling the epidemiologic profile
- [ ] Conducting the needs assessment
- [ ] Prioritizing needs
- [ ] Determining interventions
- [ ] Prioritizing interventions
- [ ] Writing the prevention plan

Section I. Background

1. Tell me a little about your own experience in HIV/AIDS prevention or care, either through your employment or as a volunteer. [***Probe:*** *volunteer work, church activities, fundraising, organizational boards, etc.*]

2. How did you become a member of this group? On what basis were you selected?

3. What are your tasks and responsibilities within the group?

II. The Community Planning Process

1. We'd like to learn more about the entire process which your CPG has undertaken. So, beginning with the nomination process, what would <u>you</u> define as an open process?

   1.1 To what degree did the health department fulfill that definition?

   [ ] A lot [ ] Somewhat [ ] Not at all

   Please explain. [***Probe:*** *How did the health department go about making the nominations an open process?*]

2. In what ways were people outside of the present CPG included in the nomination process?

3. Have members of the CPG needed any practical assistance to make participation in the group easier? [***Example:*** *transportation or child care?*]

   [ ] Yes [ ] No

   If yes,
   3.1 What types of assistance were provided? By whom?

   If the respondent needed assistance but none was provided:
   3.2 What do you think would have made participation easier? Do you know why it hasn't been provided?

4. Have members of the CPG required any training to enable them to participate fully in the planning process?

[ ] Yes [ ] No

If yes,

4.1 What types of training or TA have been provided? By whom?

For everyone:

4.2 What (additional) training would have been helpful?

5. How is conflict within the group resolved?
[***Probe:*** *Please give me some examples of specific procedures that are used.*]

6. Would you say that the viewpoints of all members are heard?

[ ] Yes [ ] Somewhat [ ] No

If yes or somewhat,

6.1 What helps to ensure that viewpoints are heard?

If somewhat or no,

6.2 What are barriers to hearing each others' viewpoints?

7. What are the procedures for handling complaints and/or grievances within the group?

7.1 How effective would you say they are?

8. How well do you think the epidemiologic profile reflects your community?

8.1 How do you think that it could be improved? [***For example,*** *what additional epidemiologic information would be important?*]

9. Are you satisfied with the Needs Assessment?

[ ] Yes [ ] No

If no,

9.1 How would you like to see it changed? [***Probe:*** *What could be added to make it more complete?]*

10. **How were the identified needs prioritized?**

10.1 **Is there anything that you would have changed about the process for prioritizing the needs?**

11. **What would you like to change or add to the community plan in order to better reflect priorities in this jurisdiction?**

12. **In your opinion, are the planned interventions sensitive to the cultural and language differences of target populations?**

[ ] Yes [ ] Somewhat [ ] No

12.1 **Please explain.**

13. **Would you say that the planned interventions are sensitive to women's needs and issues?**

[ ] Yes [ ] Somewhat [ ] No

13.1 **Please explain.**

14. **In what ways did non-CPG members participate in development of the plan?**

15. **How have community members reacted to proposed interventions?**

16. **How did the October 3rd deadline for producing the plan affect the CP process?**
[*Probe: What would you have done differently if there had been more time?*]

17. **What facilitated or helped make the CP process easier for your group?**
[*Probe: Tell me about any characteristics of your group or jurisdiction that made the process easier.*]

18. What were the major barriers which your group experienced during the community planning process?

18.1 How did the group attempt to overcome these barriers? Were there any that could not be overcome?

19. In what ways is the community planning process meeting your own expectations? Not meeting them?

20. What would you call a community? [*How would you define the term community?*]

20.1 In what ways is the CP process promoting this concept or hindering it?

20.2 What kinds of things have you learned are important to members of this community?

21. What effect do you think the HIV prevention CP process is having on existing programs?

21.1 What effect do you think the process will have on future HIV prevention interventions?
[***Probe:*** *Do you think the quality of these interventions will improve in the future? Can you give us specific examples of improvements or new interventions planned?*]

22. If you could change anything about the CP process as you've experienced it so far, what would you change? What worked well?

[***Probes:*** *If a new City got funded to started a CPG, what advice would you give them?*]

THANK YOU VERY MUCH

HIV PREVENTION COMMUNITY PLANNING
INTERVIEW FOR COMMUNITY PLANNING GROUP MEMBERS
(Short Form for Telephone Interviews)

My name is_____, and I am from the Battelle Memorial Institute. We have been asked by the Centers for Disease Control to learn more about the way in which Community Planning is working in two cities which have specific Community Planning Groups (CPGs) for HIV Prevention. We are not evaluating this CPG. Instead, we are compiling a short report of information that will be used to improve community planning in the future.

When we finish speaking with people in your community, we will share a draft report on this information invite your suggestions for improvement. At no time will we ever attribute a specific comment or quotation to anyone. Once we make final revisions to this report it will be sent to CDC. At that time too, no specific responses to questions or statements will be identified as coming from any particular participant in this study.

Do you have any questions before we begin?

****

Date: **Location:**

****

Name of Interviewee: _____
(for tracking purposes only - not to be reported)

Affiliation: _____ **Title:** _____

Stages of Community Planning (CP) in which you were involved:
[*Check all that apply*]

[ ] Nominating CPG members
[ ] Compiling the epidemiologic profile
[ ] Conducting the needs assessment
[ ] Prioritizing needs
[ ] Determining interventions
[ ] Prioritizing interventions
[ ] Writing the prevention plan
[ ] Reviewing the prevention plan

Section I. Background

1. Tell me a little about your own experience in HIV/AIDS prevention or care, either through your employment or as a volunteer. [*Includes: volunteer work, church activities, fundraising, organizational boards, etc.*]

2. How did you become a member of this group?

3. What were your tasks and responsibilities within the group through October 3, 1994?

II. The Community Planning Process

1. We'd like to learn more about the entire process which your CPG has undertaken. So, beginning with forming the group, how would you describe the nomination process? For example, was it an open process?

2. What would you say was the purpose of the Community Planning group? How were you made aware of this purpose? When?

3. Have members of the CPG needed any practical assistance to make participation in the group easier? [*Example: transportation or child care?*]

   [ ] Yes [ ] No Please explain.

4. Have members of the CPG required any training to enable them to participate fully in the planning process?

   [ ] Yes [ ] No

   Please tell us about the kinds of training you received, and what kinds of training you would have liked to have received.

5. How well do you think the epidemiologic profile reflects your community?

6. If you are not completely satisfied, how do you think that the epidemiologic profile could be improved?

7. Are you satisfied with the Needs Assessment?

[ ] Yes [ ] No

Please explain.

8. Is there anything that you would have changed about the process for prioritizing the needs?

9. What would you like to change or add to the community plan in order to better reflect priorities in this jurisdiction?

10. In your opinion, are the planned interventions sensitive to the cultural and language differences of target populations?

[ ] Yes [ ] Somewhat [ ] No

Please explain.

11. Would you say that the planned interventions are sensitive to women's needs and issues?

[ ] Yes [ ] Somewhat [ ] No

Please explain.

12. In what ways did non-CPG members participate in development of the plan? in responding to the plan?

13. How did the October 3rd deadline for producing the plan affect the community planning process?

14. What would you have done differently if there had been more time?

15. **What facilitated or helped make the community planning process easier for your group?** ***[For example, what went particularly well?]***

16. **Would you say that the viewpoints of all members are heard?**

    [ ] Yes [ ] Somewhat [ ] No

    Please tell us why you answered as you did.

17. **What were the major barriers which your group experienced during the community planning process? How did the group attempt to overcome these barriers?**

18. **In what ways is the community planning process meeting your own expectations? Not meeting them?**

19. **What would you call a community?** ***[How would you define the term community?]***

20. **In what ways is the community planning process promoting or hindering the development of community?**

21. **To your knowledge, what effect is the HIV prevention community planning process having on existing programs? future programs?**

22. **Do you have any additional comments?**

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.

INTERVIEW FOR COMMUNITY MEMBERS
(Not in CPG)

My name is _____, and I am from the Battelle Memorial Institute. We have been asked by the Centers for Disease Control to learn more about the way in which Community Planning (CP) is working in two cities which have Community Planning Groups (CPGs) for HIV Prevention. We are not evaluating the CPG in your community. We are merely compiling a short report of information that will be used to improve the CP process in the future.

We obtained your name from a list of people who participated at a Town Meeting about the HIV Prevention Community Plan last Fall. Greg Hutchens, now employed at AHA as Coordinator for the CPG, submitted this list to us at our request. Should you like to participate, we can guarantee that at no time will we ever attribute a specific comment or quotation to anyone. Once we make final revisions to this report it will be sent to CDC. At that time too, no specific responses to questions or statements will be identified as coming from any particular participant in this study.

Do you have any questions before we begin?

****

Name of Interviewer: _____

Date: _____ **Location:** _____

Name of Interviewee: _____ **(for in-office tracking only)**

Affiliation or area of expertise: _____

****

1. Have you been consulted during the process of nomination, recruitment, community planning or developing the community plan even though you are not an official member of the CPG?

   [ ] Yes [ ] No [ ] DK

   If yes,
   1.1 Which aspects of the process were you consulted about?

2. How else have you or other community members not a part of the CPG contributed to this process?

3. Were you aware of the process for nominating and recruiting Community Planning Group (CPG) members?

   [ ] Yes [ ] No [ ] DK

   3.1 Would you say the process was open?

   [ ] Yes [ ] No [ ] DK

   Please explain.

4. Looking at the composition of the CPG, do you think that the members represent the community?

[ ] Yes [ ] No [ ] DK

If no,

4.1 What groups are missing? What could have been done to make the group more representative?

5. Have you seen the Epidemiologic Profile?

[ ] Yes [ ] No [ ] DK

If yes,
5.1 Do you think it is accurate?

[ ] Yes [ ] No [ ] Somewhat [ ] DK

5.2 How could it be improved?

[***Probes:*** *What is missing? Did it identify all the target groups? If not, which groups are missing? What else needs to be changed?*]

6. Have you seen the Needs Assessment?

[ ] Yes [ ] No [ ] DK

If yes,
6.1 Do you think it is accurate?

[ ] Yes [ ] Somewhat [ ] No [ ] DK

6.2 How could it be improved?

[***Probes:*** *What is missing? What else needs to be changed?*]

7. Have you seen the HIV Prevention Plan itself?

[ ] Yes [ ] No

If NO, skip to Question 11.

If yes,
7.1 Is it satisfactory?

[ ] Yes [ ] Somewhat [ ] NO

7.2 How could it be improved?

[***Probes:*** *What is missing? What else needs to be changed?*]

8. Do you think that the planned interventions are sensitive to the cultural and language differences of target groups?

[ ] Yes [ ] Somewhat [ ] No [ ] DK

Please explain.

9. Do you think that the planned interventions are sensitive to women's issues and needs?

[ ] Yes [ ] Somewhat [ ] No [ ] DK

Please explain.

10. Do you think the community will accept the interventions?

[ ] Yes [ ] No [ ] DK

Please explain.

11. What expectations did you have of the Community Planning process?

12. To what degree are your expectations being realized? Please explain.

13. Overall, what effect do you think the HIV prevention CP process is having on existing programs?

13.1 What effect do you think the process will have on future HIV prevention interventions?

[Probe: Do you think that the quality of these interventions will improve in the future? Can you give us specific examples of improvements or new interventions planned?]

14. If you could change anything about the Community Planning process, what would you change?

THANK YOU VERY MUCH

HIV PREVENTION COMMUNITY PLANNING
GROUP INTERVIEW GUIDE FOR MEMBERS

Location: _____ **Date:** _____

Lead Interviewer: _____

Number of people in the group interview: _____

INTRODUCTION

Welcome. Thank you all for coming. We realize that you have many things to do at this time, and appreciate that you volunteered to participate in this group discussion about the HIV Prevention Community Planning Process in Los Angeles/ Washington D.C.

My name is _____. My colleagues are _____ and _____. We are from the Battelle Memorial Institute in Seattle, WA / Arlington, VA and have been asked by the Centers for Disease Control to help them gain a better understanding of the HIV Prevention Community Planning Process in different areas of the country. Our task today / tonight is to listen to and learn from you, the experts. It is important that we be able to bring your ideas, experiences, and suggestions back to the planners and policy makers so that your efforts can be supported, and - hopefully - obstacles overcome.

We are not here to evaluate anyone, nor can we help you to resolve any issues. We are here as impartial observers and listeners.

We hope to have an open and relaxed discussion with you for approximately one (one and 1/2) hour. We have a list of issues and questions. Please feel free to express your feelings, opinions, ideas, and concerns. You do not have to agree with each other and it is important to hear from all of you.

We are using a tape recorder because it is not possible to take adequate notes in a group discussion. We will review your discussion in the privacy of our office. No identifiers will be added to the tape. We will use information from this meeting in a report that will be sent to CDC in early 1995. Before sending the report to CDC we will do a presentation on it here so that we get ideas for improvement from you. At no time, whether at the presentation at your CPG, or in the report sent to CDC, will any statements be attributed to any individual.

Do you have any questions about the purpose of this group, or our methods for keeping identities confidential?

I. The Community Planning Process and the CPG

1. How did each of you become involved in this Community Planning Group?

2. How were community-based agencies and organizations (CBOs) involved in planning HIV Prevention activities and interventions before the process which led to this particular CPG began?

   [***Probes:*** *Which individuals and agencies undertook leadership roles? Who else was involved?*]

3. How was this CPG formed? Who were the leaders and how did they identify others? Was there a time frame or other guidelines for nominating and recruiting members? How could the process have been improved?

4. Looking at the group over the past year, how do you think it is operating now?

5. Are more CPG members participating actively than earlier in the process? Why or why not?

   5.1 How about nonCPG members? Are they participating in the planning process? How?

6. What additional areas of expertise would you like to see represented on the CPG?

7. Have there been changes in communication to assist people to participate more fully?

   [***Probes:*** *How are cultural differences, differences in values, or life experience including sexual orientation handled? What about handling conflict? Would you say that men and women and all groups are heard and involved?]*

8. What were your sources of information for developing the community plan? How did you get this information?

   [***Probes:*** *Who explained the different types of information (e.g., epidemiology) to people with other kinds of backgrounds? Were these explanations adequate?]*

9. What would you say is the most innovative or unique feature of your current HIV Prevention Plan?

10. **What do you think are some of the problems with the current plan? How are they being resolved?** (*How could they be resolved?*)

11. **Looking back over the time that this group has been in existence, what were some of the things that went particularly well?**

12. **What have been some of the major barriers in achieving your goals as a group? The goals of the constituency you represent within this group?**

13. **What advice would you give to CDC to improve the HIV Prevention Community Planning process?**

II. Summary

1. **Overall, what effect do you think the HIV prevention CP process is having on existing programs?**

   [***Probe:*** ***Please be as specific as possible.***]

   1.1 **What effect do you think the process will have on future HIV prevention interventions?**

   [Probe: ***Do you think that the quality of these interventions will improve in the future? Can you give us specific examples of improvements or new interventions planned?]***

2. **What are the biggest obstacles to carrying out HIV prevention education and other interventions in this community?**

3. **How do you think the CPG is helping to overcome these obstacles?**

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.
DO YOU HAVE ANY FINAL QUESTIONS FOR US?

HIV PREVENTION COMMUNITY PLANNING GROUP
MEETING OBSERVATION GUIDE

Date: _____ **Location:** _____

Observer(s): _____

_____

_____

Start time: _____ **Ending time:** _____

1. Is this a meeting of the entire CPG or a subgroup? (If subgroup, what is its nature?)

2. Who is leading the meeting? Is leadership and/or facilitation divided? How?

3. How many people are attending the meeting? In general, what constituencies are they representing?

4. What is the nature of Battelle's interaction with the group (e.g., introducing ourselves, describing the study, conducting a survey)? What is the reaction of the group?

5. Please describe the meeting and any activities conducted in detail. Include nature of interactions, handling of conflict, level of inclusion, etc.

Battelle

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